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ABSTRACT

This practicum project sought to improve the care of students with cognitive dysfunction through more effective interdisciplinary collaboration of mental health and education professionals. The project's objectives included increasing child psychiatric residents' knowledge of educational programs, and having consultation reports indicate inclusion of the components of a functional approach checklist designed to be included with each evaluation report sent to a school setting. A seminar was developed and presented to the child psychiatric staff in training at a medical college/hospital. The seminar covered the purpose of assessments, adaptive strategies in assessments, steps in creating developmental linkages, and a case study outlining assessment results and the individualized education program derived from the assessment. Using a pretest/posttest procedure, 19 of 20 residents showed a marked increase in their knowledge of the need for linkage between assessment and educational programming. Appendices include copies of questionnaires and questionnaire results, the pretest/posttest and results, the functional approach checklist, an outline for the seminar lecture and accompanying overhead projector sheets, a seminar handbook, and a seminar evaluation form and evaluation results. (JDD)

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Developing Functional and Practical Application Strategies for the Psychiatric Reports of School Age Special Needs Children Through Inservice Training

by

Bonita Louise Kincade

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NOVA UNIVERSITY

Developing Functional and Practical Application Strategies for the Psychiatric Reports of School Age Special Needs Children Through Inservice Training

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Bonita Louise Kincade

Cluster XXVI-A

A Practicum I Report Presented to the Ed.D Program
in Early and Middle Children
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1988

PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by Bonita L. Kincade under the direction of the advisor listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

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3/25/88
Date of Final Approval of Report

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ABSTRACT

DEVELOPING FUNCTIONAL AND PRACTICAL APPLICATION STRATTEGIES FOR THE PSYCHIATRIC REPORTS OF SCHOOL AGE SPECIAL NEEDS CHILDREN THROUGH INSERVICE TRAINING. Kincade, Bonita Louise, 1988: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood. Descriptors: cognitive dissonance / cognitive objectives / cognitive psychology / cogntive restructuring / cognitive structures / cognitive tests / individualized instruction / mental health clinics / mental health programs / psychiatric services / psychoeducational services / psychological services / social cognition / special education

This practicum addresssed the problem that teachers and other educational specialists receive little direct, practical guidance from diagostic specialists regarding the design of individualized treatment plans for the cognitive dysfunction child. There has existed a voiced interest in the need for early identification and comprehension assessment of cognitive dysfunction problems but little direct concern with this serving as a blue print for designing the instructional programs.

The primary goal was to improve the care of special needs children through more effective utilization of the educational program as part of the collaborative treatment program for these children.

This writer surveyed 15 mental health professionals and 56 educational professionals to ascertain their opinions and concerns on the present status of diagnostic reports and their implications for instructional planning. Interviews with psychiatrists and school principals were also used for further documentation. The results developed were utilized to develop a seminar to address these salient issues and to be given to the child psychiatric staff in training of this writers medical college/hospital.

The objectives included (1) an increase of knowledge of the educational programs and (2) the inclusion of all components of the Functional Checklist which was developed by this writer. The first objective was measured with pre and post testing and the second objective was measured by the inclusion of the checklist items in the final reports being examined by the supervising psychiatrists.

The results were positive. The posttests scores showed marked increase of knowledge. Feedback from the residents exhibited their cognizance of the need for linkage of assessment and educational programming. Evaluations by the Director of Child Residents and the Department Chair were also favorable.

CHAPTER 1

INTRODUCTION

Description of Community

The medical center in which the practicum took place is in a rural community located at the foothills of an extensive mountain range on the eastern coast of the United States. It is within a 200 mile radius of several major metropolitan areas. Despite its steady growth over the past 20 years, the community has remained constant in its small-town atmosphere. The quality of life is very good; this is made possible by the unusual combination of urban-cultural attainments being grafted on a peaceful rural community.

Today, the community has a population of approximately 7000 residents. The founder of this town was very much a humanitarian in his concepts of how a community should evolve. He wished to establish "a real hometown." The growth of the community is three-fold. A major food corporation is the backbone of the local economy. It has worldwide distribution encompassing many subdivisions. There are many resort/recreation facilities within the community as well. A large influx of visitors supports the diverse vacation attractions. Finally, the medical center was begun in 1963. This accounts for the largest influx of residents to the community.

The socio-economic make-up of the community is generally upper-middle to upper class. The medical center has led to a number of wealthier families moving into the area.

Writer's Work Setting and Role

The medical center in which the practicum was conducted has experienced rapid growth since its conception in 1963. Today it is a $70 million university medical center which occupies 216 acres. It has a three-fold purpose: education, patient care and research.

There are more than 400 medical students in the four year MD program. Approximately 25% of them are women and a smaller percentage are minorities. Graduate degrees are available in the sciences of anatomy, biological chemistry, genetics, microbiology, pharmacology, physiology and laboratory animal medicine. In addition, over 100 physicians are serving as residents. More than 70 nurses are working towards their B.S. degree at this facility. There was also a program to train former military corpsmen as physicians' assistants.

Patient care is provided through the 362 bed hospital. Every patient is involved in teaching and is seen by a team of faculty physicians, residents, and medical and nursing students. In addition to medical/surgical units there are ICU, CCU, neonatal ICU, adult and child psychiatry units, plus numerous out-patient facilities which see more than 50,000 patients a year. Research, the third facet of the university medical center, is conducted by both basic and clinical faculty members and by students. A recent grant from the National Cancer Institute of Health made possible construction of a basic sciences-cancer research wing.

The Department of Psychiatry constitutes one of the nine clinical departments of the College of Medicine. The administrative

and educational facilities, as well as adult and child inpatient units and outpatient centers are located within the medical center facility. Currently, the department provides a full range of clinical services for psychiatric care, including a very active hospital consultation-liason service. The department is responsible for teaching medical students in all four years of the medical curriculum. Additionally, the department is engaged in the development and implementation of highly sophisticated programs of psychiatric research. A fully accredited four year residency training program in psychiatry as well as an accredited two year fellowship in child psychiatry are offered and are the primary activities of the department.

New to the department is the development of a neuropsychological lab. It will be able to provide direct clinical service as well as a strong data base with respect to fowarding research in the neurobehavioral domain. The role of this writer will be to provide treatment strategies and/or services as they may apply to patient recovery of function, or as they may relate to rehabilitative services, patient adjustment, or educational planning. Additionally, this writer is involved in working with a group supported by a one million dollar grant from the Department of Education whose function is to provide community based education seminars on salient mental health issues. The audiences reached include professionals from the following disciplines: mental health, medicine, education, and social services.

The educational and work experience background of this writer is

an ecclectic array. After an M.A. in Mathematics Education, a career teaching secondary math ensued. The graduate thesis dealt with Piaget and the development of a mathematical model using his logic as a basis. It was very process oriented and not product related. This interest developed through work with low achievers and other students doing poorly in school. It led to working with SED (seriously emotionally disturbed) children in a hospital inpatient unit. This writer then was asked to develop a survival skills and pre-vocational program for TMR (trainable mentally retarded) adolescents in a private school facility. This was to include very basic functional reading, time, money, and workshop related skills and behaviors. This was a three year project. In 1984, the private special education school where this writer was a faculty member, was approached by the Middle States Association of Accreditation. The school was asked to be a part of the pilot program for designing an accreditation procedure for special education facilities. This was the first faciltiy in the state to receive such accreditation for the mentally handicapped. This writer was the primary composer of the self study and was later asked to serve as a visiting team member. Within that school this writer served as mathematics coordinator whose responsibilities included curriculum development in mathematics and thinking skills for MR (mentally retarded) students 0-21 years of age with a mean IQ of less than 50.

At the end of the three years this writer began to work at the present site of employment. Additional involvement over the years included being a member of the Speaker's Bureau for Women in

Mathematics and being a referee reader for the journal Arithmetic Teacher. This writer has also been a judge for the state Junior Academy of Science as well as a presentor at the Academy of Science Convention. Within the past two years this writer has become part of a group to give diocesan-wide workshops in the areas of assertive discipline, problem solving, and thinking skills.

CHAPTER II

STUDY OF THE PROBLEM

The Gap Between Child Assessment and Programming

The assessment of handicapped children can be the key to quality programming. Educators know the value of good diagnostic information in formulating individual educational plans (IEP). Unfortunately, however, assessment reports made available to teachers are often lacking in practical and functional significance to the school setting. Assessment often provides only remote, if any, implications for educational programming. Yet, forging effective linkage between assessment and treatment is vital for the developmental/educational progress of handicapped children.

Traditionally, there has existed a voiced interest in the need for early identification and comprehensive assessment of cognitive dysfunction problems but little direct concern with constructing individualized educational plans based on the results of such assessments. This, the crucial bond between assessment and intervention, has usually been bypassed. Teachers and other education specialists have received little direct, practical guidance from diagnostic specialists regarding the design of individualized treatment plans for the cognitive dysfunction child.

Federal Public Law 94-142 (94th Congress, 1975) represents a major step towards ensuring that comprehensive assessment methods serve as guides to IEP's for all handicapped children. The provisions of PL 94-142 define the impact of mandated procedures upon the role of all individuals who must program for the handicapped child. The central theme implicit in PL 94-142 is accountability for the educational progress of handicapped children. In essence, the assessment yields data on current educational performance which leads to individually planned goals for each handicapped child.

Although such individualized assessment and programming procedures mandated by PL 94-142 are not new to diagnostic specialists, the unique thrust of this law is that individualized methods and procedures will be increasingly required for the young and severely handicapped child within the public schools. The impact of the law in the typical roles, functions and relationships of diagnosticians, teachers, and parents is enormous.

Central to the role and function of the school diagnostician is the assessment and prescription for psychoeducational problems. However, the process of assessment is devoid of practical, functional significance unless it serves as a blueprint for designing individualized instructional programs.

Documentation of the Problem

In order to provide documentation of the before mentioned problem, this writer solicited the professional opinions of local

professionals in this area. Questionnaires and interviews were the major resources used to compile this data.

Professionals in the fields of mental health were sent an eight point questionnaire (Appendix A). These fields included child psychology, hospital psychology, school psychology, and clinical psychology. A total of 15 questionnaires were distributed with 100% returned. The results of the entire questionnaire are in Appendix B. The primary diagnosis question contained a broad array of cognitve dysfunctions with ages ranges of 2.6 years through adults as well as various levels of functioning. Eleven professionals required some form of written background information from the school setting and 10 required such written information from the home. In regard to requiring interviews, 5 said NO and and the other 10 required interviews only occasionally. Where applicable, the teachers and parents alike were found to be cooperative. With regard to supplying practical information to the families to implement in the home or making suggestions to the school setting, there was total agreement. No such requests were made. The consensus was that a referral was made, the testing was completed, and the evaluation was sent to the requesting party. There did not appear to be much open communication.

To examine the other side of this issue, a questionnaire was sent to professionals in the education field (Appendix C). The breakdown consists of the following: 9 area Intermediate Units, 1 rehabilitation center, and 1 private school for the mentally

handicapped, for a total of 56 professionals. There was a 100% return. The nine point questionnaire brought to light a matrix whose elements were rather consistent. The results of this questionnaire can be found in Appendix D. The age range was from 0-21 years of age with a primary diagnosis of multiple cognitive dysfunctions. 100% of the students were referred for various types of testing. In most cases, (53:56) the teachers replied that they had to provide some information to the examiner prior to testing but in all 56 cases there was no inclusion of parent and/or teacher interviews. The only feedback provided was the written evaluation. In the private school, only, a teacher could request a meeting with the examiner and parents (8:56). There were no concrete suggestions sent home and only "hit and miss" efforts at follow-up. The reports are also devoid of educational methodologies for use in the classroom or planning of an IEP. Brief inferences were made on the part of the teachers with regard to their requests for more information. On a scale of 1 (very poor) to 7 (excellent), the average was 3 (fair).

The surveys provided convincing evidence of the large gap between the needs and services rendered to the child. Both sides of the coin seemed to sense a lacking but they did not verbalize these concerns to the other party. This was clearly exemplified in the interviews held.

The principal was very eager to talk with this writer and share her concerns. The top priority issue, with her, was that although her students definitely needed neuropsychological

evaluations, they were not entitled to them because this was not a covered psychological expense. The reports sent to her reiterated what she already knew. They "labeled" the children, giving little or no additional information. This principal was also concerned with feedback for the parents. The populations her school serviced needed "hands-on" practicality. The majority of the parents did not understand the reports and were intimidated by them, thus afraid to ask questions or seek additional help.

Interestingly, the interview with a child psychiatrist faculty member shed a completely different light on this issue. He felt very strongly that it was not the role of the medical profession to provide educational methodologies to school settings. It was "the responsibility of the the teaching staff" to increase their knowledge of the needs of the children with cognitive dysfunctions. He was not completely adverse to finding a "middle ground" to work with, if it were indeed medically oriented.

Causal Analysis

The essence of school diagnostic practice is to determine the match between a handicapped child's capabilities and the effective features of a treatment program. There are several important practical issues related to why assessment has not been as helpful as it could be and why school diagnosticians have had difficulty in providing teachers with instructionally relevant reports.

Issue 1:Traditional Assessment Purposes and Practices

Traditional practices in assessment, which emphasize the

exclusive use of global, norm-referenced, intellectual measures for the purpose of describing a child's range of abilities, are clearly inappropriate when applied to handicapped school age children. Beyond their inappropriateness and lack of precision in an evaluative scene, such methods are ineffective in terms of creating a link between diagnosis and intervention (Chase, 1985).

The ambiguity, lack of precision, and absence of continuity in testing and teaching the handicapped appear to result from a failure to understand the purposes of assessment with such children. Haphazard and ill-suited goals and methods lead to gross misjudgments and considerable wasted effort.

Assessments are conducted for a variety of purposes but primarily to make individual decisions about the essential features of a child's treatment/education program. The type of decision made dictates the kind of skills assessed and the type of measure selected.

Traditional assessment practices operate as if they were separate operations (i.e., screening, identification, placement, and progress).

Issue 2: Categorical versus Functional Orientation

Traditional assessment has been aimed at diagnosis of a child's "condition"; that is, the main purpose has been identification of a child's primary disability area or diagnostic category. The result is usually an assessment report that tells the teacher what a child <u>is</u>, rather that what a child <u>does</u>. "Bill is retarded," "Martha is sociopathic," or "Harry is emotionally

disturbed." Notice that these are diagnostic statements that label a child with some categorical so-called underlying condition. This approach may be termed genotypic assessment because it attempts to identify a general, underlying problem. In contrast, a more useful approach, phenotypic assessment, attempts to describe and summarize what capabilities a child does or does not display. Unfortunately, genotypic diagnosis does not provide much guidance for instruction. The major limitations of this type of approach are: (1) various exceptionalities are not distinct or pure; a diagnostic label does not automatically accurately describe a child's functional problem and (2) identification of a disability area does not automatically suggest preferred treatment.

Issue 3: Translating Assessment Results for Goal Planning

The report is one of the primary vehicles through which diagnostic specialists demonstrate the value and effectiveness of their services. Moreover, this report is a vital step in the process of clearly communicating information regarding a child's capabilities to parents and teachers and of translating data for instructional planning. With the rise of specialized services to exceptional children, the critical importance of quality reports increases. However, criticism by parents and teachers (supported by the results of descriptive research) suggests that traditoinal diagnostic reports are ineffective as guides to individualized curriculum planning. Traditional reports are often test-centered, ambiguous, authoritarian, and confusing,

contributing little to the current programmng needs of the child. In practice, there are three difficulties with traditional reports:

1) Failure to identify the purpose of the assessment directly affects the meaningfulness of the information provided, given the needs of the child. Often, the primary assumed purpose of assessment is to predict future cognitve performance and adaptive functioning. However, contrary to the usual perspective, prediction contributes information of only limited use to teachers or parents. The apparent need for predictive data is often reflected in such questions as "What can we do to help our child learn to talk?" Without answering these questions regarding the degree of dysfunction, cause, and strategies, the diagnostician who provides only predictive data leaves the parents of a handicapped child with a sense of confusion, hopelessness, and helplessness. Furthermore, predictive data provide no precise information to guide intervention/teaching strategies and are often based on a limited sample of behavior that frequently leads to erroneous conclusions regarding later functioning.

2) Vague, imprecise presentation of functional information makes a report meaningless. This poor quality occurs when reports focus on their test-centeredness, lack of scope, and limited relevance to a child's functioning in educational contexts. The organization, content, and style in the application of reports must be modified to maximize their usefulness to the teacher.

3) There is a failure to link the assessed child's needs to

specific intervention goals and targets. Traditional reports involve both a quantitative and qualitative breakdown of assessment results. they are organized by traditional subheadings of background information, behavior objectives, results, analysis, and discussion. Global reccommendations, only, are suggested.

Related Research

Few controlled studies have dealt with the practical problem of matching assessment tasks from traditional instruments with activities from curricula in order to facilitate diagnostic-prescriptive teaching. However, the results of peripherally related studies lend research support to the linkage concept (Meeker, 1979; MacTurk & Neisworth, 1978; Caldwell & Drachman, 1984; Fowler, 1982; Gordon, 1979; Morrison & Potheir, 1982; Valett, 1978).

Meeker (1979) devised a method of assigning Stanford-Binet items to cells in Guilford's Structure of the Intellect. Using interjudged reliability and factor analysis procedures to validate the match, Meeker demonstrated that congruent behaviors were being sampled within both test activites and Guilford's theoretical structure when groups of children performed on both sets of tasks. Furthermore, case studies of gifted children gave evidence that patterns of abilities and deficits on congruent Binet-Guilford tasks could be reliably matched with activities from commercially available curricular materials to facilitate individualized programming in perceptual, language, and problem solving areas.

In a study that compared the differential utility of

normative and criterion-referenced measurement procedures in a mainstreamed preschool setting, McTurk & Neisworth (1978) evaluated the developmental progress of 20 handicapped and nonhandicapped preschoolers over a six month period. Intercorrelations between Gesell diagnostic results from a psychologist and teacher-evaluated curriculum progress ranged from r=.61 to .93 for both groups with a mean correlation of r=.91 for the handicapped group. The results reflected a developmental similarity between Gesell test behaviors and HICOMP curriculum objectives and supported the usefulness of traditional developmental scales as reliable criterion-based measures of individual child progress and intervention effectiveness. Moreover, other similar studies (Bagnato, 1980; Bagnato & Neisworh, 1979) demonstrated that preschool teachers can easily learn to extract norm-based developmental data and targets from psychological reports and to match accurately such targets to appropriate curriculum objectives (r=.88).

Similarly, Caldwell & Drachman (1984) compared three methods of assessing the current developmental functioning of 52 infants aged 1 to 2 years. The Griffith, Cattell, & Gesell scales were chosen because of their mutual inclusion of similar developmental tasks. Results indicated that the correlations across age levels among the three scales were described by a range of r=.77 - .98, significant at the .01 level. The study supported the objectivity of the scales as measures of current functioning and the developmental similarity of tasks compromising the infants scales.

Fowler (1982) reported a Canadian study in which individualized assessment-based programming was instituted for 39 infants, ages 2 to 30 months. Multiple developmental domains were surveyed using the Bayley scales, the Stanford-Binet, and the Infant Behavior Inventory, and sequenced developmental objectives were established for each child. Significant increases in skill acquisition were revealed over a one year period. Success was attributed to the individualized programming based upon "diagnostic developmental monitoring" (p. 153) in which teachers received periodic profiles of each infant's rate of learning within multiple areas.

Gordon (1979) studied the impact of an intensive inpatient developmental program on 40 multihandicapped children aged 18 to 36 months, and their parents. Results demonstrated that assigning developmental age levels to matching performance on test activities and instructional tasks yields significantly more relevant information about child progress.

In a similar study, Morris & Potheir (1972) evaluated the developmental progress of 30 mentally retarded preschoolers with a mean age of 49 months. Sensorimotor activities were individually prescribed upon performances on traditional developmental scales. The results demonstrated the significant advantages of employing a detailed analysis of sensorimotor deficits as a basis for selecting specific remedial activities.

In summary, the conclusion to be drawn from an array of clinical assessment approaches and research studies is that

traditional developmental scales can be reliably employed as measures of current functioning and as criterion-based guides for individualized programming for children with cognitive dysfunctions.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Statement of General Goals

Systems of classification do not solve problems. On the other hand, a classification system frequently makes a problem clearer so that one can see the essential elements of a complicated situation and, thus, take steps towards its partial or complet solution. This is very true in the fields associated with special needs children. As a result, the goal of this practicum was to improve the care of special needs children through more effective utilization of the education program as part of the collaborative treatment program for these children.

Behavioral Expectations

An analysis of the literature exposed the sparseness of studies which dealt specifically with the practical issues involved in this practicum. However, the peripheral studies gave light to the concept of bridging or linking the two fields into an interdisciplinary involvement. The writer chose two specific objectives with this in mind. The first objective dealt with specific knowledge being increased and the second objective was to maintain the implementation of that knowledge. Therefore, the following specific objectives were chosen for this practicum.

OBJECTIVE 1

All child psychiatric staff in training will increase

their knowledge of the educational program by responding correctly to 8 out of 10 items on the post test (Appendix E).

OBJECTIVE 2

All consultation reports will indicate inclusion of all components of the Functional Checklist to be developed by this writer. The report will be checked by the supervising psychiatrist before being released.

Evaluation Instrument and Measurement

The first objective was measured by a writer-prepared post test (Appendix E) consisting of six "fill in the blank" sentences and four True or False statements. This type of evaluation tool was chosen because it allowed the examinees to reveal their understanding of the material and test their ability to apply their knowledge. The total of ten was chosen as a sufficient number of questions to cover the material.

The second objective was measured by the use of a writer prepared checklist (Appendix F). The Functional Approach Checklist consisted of core items to be included when preparing an evaluation report to be sent to a school setting. It was generic in nature so as to be applicable in numerous situations. The vocabulary used was that which had been presented and tested earlier. This ensured proper understanding and usage of the terminology. The evaluation tool of this objective was to have the supervising psychiatrist examine the report prior to release to ascertain that all the checklist items were covered. This afforded the

resident the opportunity to have the supervisor not only check for the accuracy of the materials included but to have this added skill refined.

Mechanism for Recording Unexpected Events

In the implementation of a project that extends over a period of time and involves several variables, provisions must be made for unexpected occurences. In order to accomodate these atypical events, the writer kept a weekly log (Appendix G) for each of the objectives. The format was that of a simple checklist to identify immediately if this writer was on task with regard to each of the objectives. If not, it identified what needed to happen/be done to rectify the matter and also, to be set on course again. This process provided a means of monitoring the progress of this practicum in two ways. It either was able to foresee a problem in the making or else it identified a problem at onset. Both results of the monitoring prevented any major inhibitors in completion of this project.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

In order to be effective and purposeful, the assessment-intervention process must be viewed as consisting of interdependent phases, each with distinct purposes but merging with the purposes of the next: screening > identification > comprehensive assessment > individualized programming > monitoring child progress.

This critical need is highlighted by Kammi & Elliot's call (1979) for designing and using developmental measures that will more effectively match the objectives of new curricula for handicapped infants and preschoolers. Expending the linkage concept further, Jordan et al (1979) and Mayer (1981) emphasized the "internal consistency" that should exist between rationale, goals, objectives, materials, instructional techniques, and assessment measures.

The Diagnostic-Prescriptive Approach is the most prominent assessment - curriculum linkage model (Salvia & Ysseldyke, 1979). It is a method for identifying the most appropriate goals and effective instructional strategies for children as an outcome of their performance on a variety of assessment instruments.

The initial outcome of performance on assessment instruments is an index of relative standing compared with

normal age peers. This is perhaps useful placement information, but not what educators need to formulate systematic intervention programs or IEP's. Optimally, assessement is just one interrelated stage of a continuum. This includes finding and precisly identifying developmental and educational delays, intervening to facilitate progress, and evaluating the effectiveness of that intervention. If any stage of this continuum is omitted, full service delivery has not been achieved. Different outcomes can be expected depending on which stages are omitted.

According to the model presented by Cromwell, Blashfied, & Strauss (1979), if the intervention stage is omitted, the continuum can function merely as a valid diagnostic appraisal and be useful only for prognosis. However, to estimate prognosis without regard to intervention is assuming that most nonnurturing environment.

Most criticism has been directed at the integrity of the diagnostic-prescriptive model regarding the reliability of the assessment instruments used, the types of behaviors assessed, and the efficiency of the interventions employed (Ysseldyke & Salvia, 1984). The use of classic assessment instruments in younger children is not reliable in predicting later intelligence.

Another avenue is the Attitude-Treatment Interaction Model. The ATI concept is primarily a research and evaluation method that seeks to identify relationships and interactions between a person's range of individual

differences and the most effective method of instruction for that person's needs (Hunt & Sullivan, 1984). Although research over several years has failed to demonstrate the effectiveness of any one instructional approach, structured educational methods using well-defined goals and strategies have the best track record with both normal and handicapped children.

Once a pattern of skills, needs, or problem solving is identified, a teaching approach or plan is designed to instruct the child in the most effective manner to accomplish various individualized objectives. This model is a useful conceptual framework for the initial stages of planning educational programs that link assessed needs with strategies.

Focusing on the specific rather than general nature of intelligence, Guliford (1978) formulated the Structure of the Intellect (SOI) Model, a theoretical model of cognitive abilities consisting of more than 120 different factors. The SOI model presents three structural dimensions of the thinking process: content, operations, and product.

Although complex and somewhat cumbersome, the SOI model presents a useful way of analyzing and visualizing the subcomponents of thinking. Guilford asserts that the levels of cognitive skills and operations can be assessed and developed through structured thinking.

Haeusserman (1978) and Jedryskel, et al (1982) have developed a Functional Education Evaluation format that

permits one to adapt assessment of the child's impairments in order to survey intact developmental functioning across several sensory and cognitive areas. The results of the "adaptive-capacity" evaluation serve as a curriculum guide, that is, a developmental profile that displays strengths and weaknesses and suggests instructional goals and strategies. In effect, one assesses the qualitative aspects of a child's capabilities and delineates the levels that represent the child's current level of maturity or operation given the disabilities.

Effective education for handicapped children rests upon common assessment and curriculum practices. The Diagnostic-Prescriptive Approach is widely used, but the information derived has often been of limited use to the special educator. Yet, the demands of PL 94-142 require a more precise and educationally relevant merger of these two operations for IEP development.

Various approaches - such as the Attitude-Treatment Interaction Model, the Functional Education Evaluation Model, the SOI Model, and the Diagnostic-Prescriptive Model - provided useful guidelines for linking assessment and intervention. However, the Developmental Task Analysis Model advanced a common framework for testing and teaching, that was developmental sequencing and task analysis. Thus, the Developmental Task Analysis Model provided the most reliable and pracatical basis for prescribing school programs.

Description of Selected Solution

The concept of using a Developmental Model attempted to offer a practical, reliable and relatively systematic method of constructing IEP's for children. The method extended the value of traditional developmental scales by using the information provided for criterion-based curriculum planning. Thus, providing a common ground for the roles of evaluator and teacher and making their skills interdependent.

Valett (1972, 1978) has taken the developmental task concept and formulated a practical plan of operation for developmentally disabled children that pragmatically integrated assessment and programming. In this approach, the tasks, skills and processes sampled on traditional performance tests are arranged in a developmental sequence or task analysis. This Developmental Task Analysis contains skills that are viewed as prerequisites for subsequent more complex learning. Specifically, developmental task analysis is a process of identifying and analyzing children's ranges of aquired (+), absent (-), and emerging ($\pm$) developing skills within multiple functional areas for the purpose of establishing "developmental targets" or goals for individualizing curriculum planning. (Many successful early intervention programs incorporate some form of developmental task analysis within their operation.)

The most reasonable and effective solution to this dilemma seemed to be the use of multimeasure, multisource approach to assessing and programming for school children.

Thus, it was proposed that traditional developmental scales, when matched with developmentally sequenced curricula, did help to forge practical assessment-curriculum linkages for handicapped children. This method reflected the influences of Vallet (1978) and Haeussermann (1978) regarding developmental task analysis and adaptive-process assessment.

In terms of formative and summative evaluation, such an approach was competency-based and enabled both teachers and examiners to monitor the progressive acquisition of developmental skills as well as program effectiveness. For example, after the linkage had been formulated and implemented, the child's progress in acquiring deficient developmental skills will be monitored primarily by curriculum-imbedded checklists and behavioral analysis. The developmental scales subsequently provided concurrent summative evidence of developmental progress.

In addition, the linkage concept offered a practical vehicle for translating diagnostic results into observable curriculum goals so that parents are aware of prerequesite skills that require stimulation. It was important to compare parent perceptions of developmental progress with the child's actual situational performance so that the parent remains a vital resource in the programming and teaching process (Bagnato & Neisworth, 1979).

To apply this solution to this particular worksetting, an in-service training seminar was implemented for the child psychiatric staff in training (residents). It was a basic

"how-to" demonstration. The rationale, purpose and objectives were be simply stated at the beginning of the seminar.

All pertinent terms, goals, and objectives were be included in the handbook given to each participant. Included also was the Checklist to be used when preparing assessment evaluations and reports.

This writer believes this method was the most conducive to success for several reasons:

1) It followed the norms for teaching methodology in the hospital residency program,

2) It fit into the teaching schedule/calendar, and

3) It was readily accepted as part of the standard, required course work.

Even though the actual seminar time was less than 1 day, the results will be carried through the remainder of the resident's term, and hopefully, into his/her practice.

The rationale for acceptance and success of this project is two-fold.

1) As previously noted, teachers are eager to receive this type of supplemental guidance and are supportive of consultations addressing themselves to these issues. The feedback the department/hospital would receive would be positive in nature.

2) The learning climate in the department is an open and receptive one. Trainers and trainees alike, are eager to explore innovative approaches that will increase their

effectiveness as professionals.

In summary, the demand for linkage between assessment and curriculum is said, by many, but it is apparent that it is not carried out into the training programs. This writer attempted to make a consciencious effort to rectify that in this Department of Psychiatry. The training seminar addressed this issue and provide concrete guidelines for the residents to implement in their assessment.

Chapter V

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Results

Objective One was measured by a writer-prepared pre/post test given to the twenty residents. The criteria for success were specified to answer eight out of ten correctly. The 80% accuracy was chosen on the basis of its equivalence to a 'B'; this being the average passing grade for the majority of graduate studies.

The pretest m (mean) was 1.25 with a SD (standard deviation) of 1.118. The posttest results revealed a m of 9.450 and a SD of only .887. That demonstrated a t score of 7.069. Only one resident was unable to meet the 8 out of 10 objective, with a raw score of 7. This particular resident appeared to be negative towards the seminar and did not seem to perceive it as a worthwhile endeavor. It is not highly significant that one resident did not meet the criteria of the objective's standard. Appendix L summarizes the test results.

Objective Two was measured by the use of a writer prepared checklist. It consisted of core items, presented during the seminar, that should be included with each evaluation report sent to a school setting. The seven 'YES' or 'NO' statements gave the resident the opportunity to review his/her report for accuracy of the materials. The

attending psychiatrists reviewed the reports prior to release to ascertain inclusion of the checklist items.

The final evaluation completed by the residents (Appendix K) was returned two months post-seminar. This allotment of time was chosen as ample time for the residents to become not only cognizant of the checklist items but to become comfortable with their use.

Of the twenty participants, fourteen were strictly child residents. The remaining six were adult residents and attended to broaden their basic background knowledge. The tabulated results of the evaluation are in Appendix M.

It is quite evident that the overwhelming majority of residents found the seminar to be pertinent. They verbalized their ignorance of school related issues and how these were not addressed in the medical training received thus far. Although they were somewhat aware of the educational component of special needs students, the importance of their reports and subsequent feedback were unrealized. The residents were quite eager to improve their communication with the schools and saw this as a means to better understand this population.

A review of the seminar with the Director of Child Psychiatry was most favorable. He felt very strongly that the residents now have a "humanizing perspective for the special needs student." He felt it imperative that the residents not lose sight of this perspective. It was much

too easy to be enveloped in clinical aspects and forget about the actual person. If they were to utilize anything from the seminar, he wanted it to be this point of being cognizant of what "special needs" entails.

A final evaluation with the Department Chair was most enlightening. He was very positive in regard to the need for psychiatrists to be aware of school placement issues. Unfortunately, he was not completely convinced that it belonged in a residency training program. He was of the opinion that, "yes, it is important to understand the special needs placement programming, but perhaps it would be best to have that as something post-residency." He expanded further that time is a critical factor; each resident has a full and demanding schedule. "There are so many important components of the resident's training that priorities must be made and adhered to. At this point in the residency training curriculum it is not imperative to include this type of seminar." He went on to add, "I see this as an excellent topic for inclusion as an elective."

Conclusions

The first objective concerned the increase of the residents knowledge of the educational program. This was met well within the established guidelines as evidenced by the data presented in the previous section.

The second objective concerned the inclusion of all components of the Functional Checklist. The material was

covered in the seminar as well as in the manual. This was evaluated by having the reports examined by the supervising psychiatrist.

An unanticipated outcome of this practicum was the enthusiasm a few of the child psychiatric residents exhibited after using the Checklist for their reports. They received positive feedback from the school setting and in turn, shared that with this writer. The more use the Checklist got, the more questions the residents had in how to better implement it.

A second unanticipated outcome was the lack of tolerance the attending psychiatrists had in regard to the use of the Checklist. The frustration level was very high and noticeably exhibited. Although the consensus was that yes, this was an important topic, it did not warrant time and energy on the part of the attending psychiatrist.

It is the opinion of this writer that there was not much support given to these attending psychiatrists. They had to deal with this on a level they were unprepared for. Their knowledge was somewhat superficial but they were expected to provide expert feedback to the resident. This, in turn, shed a negative light on the entire experience.

In conclusion, this practicum project proved that there is a need for effective linkage between assessment and treatment/educational programming. These reports must be salient in practical and functional significance to the

school setting. It is the role of the diagnostician to provide the necessary blueprints. It is clear that the present day thinking of the psychiatrist is not in agreement on this issue. As with many pioneering ideas, changes evolve over a period of time. The concept of linkage is just that. Change can and will occur as the needs are known and challenged.

Recommendations

If this practicum were to be replicated there are several changes which would facilitate a smoother more efficient execution.

It is suggested that the material be given over a period of time rather than one seminar. This would permit time for rumination of what was presented and subsequent questions and discussion would arise. A topic this foreign to the psychiatric resident should be walked though over several occasions. It is imperative they understand the WHY as well as the HOW.

Further, it is suggested that the attending psychiatrists have a clearer understanding of the Checklist. They need to have broad-based knowledge in order to facilitate its use when supervising the resident. If the attending psychiatrist is unsure of the benefits of the Checklist s/he will not and cannot verify the reported findings and suggestions, thus causing a disservice to all parties concerned. It is this writer's opinion that if the attending psychiatrist is not

cognizant of the importance of linking assessment, diagnosis, and school programming, the resident will not adhere to the Checklist items.

Dissmemination

The results of this practicum project were shared in four ways. The first was by submission of the seminar to the department for inclusion among its teaching materials and resources. These are available to all faculty within the department. The writer is available for consultation when deemed necessary.

Secondly, the practicum was sent to the main campus of the university with which the medical college is associated. It is housed in the main library.

Additionally, a copy of the practicum report was sent to the schools and facilities which participated in the questionaire survey. These were sent directly to the principals and/or department heads to share with the faculty and staff.

Finally, the practicum report abstract was given to each fellow cluster member.

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APPENDIX A

QUESTIONNAIRE SENT TO MENTAL HEALTH PROFESSIONALS

This questionnaire is being sent to you to ascertain the amount of interdisciplinary involvement between psychologists, psychiatrists, and school professionals working with children who have some degree of cognitve dysfunction. The results will be used as a major resource in designing a training seminar for professionals dealing with this population.

Thank you for your input and expertise in this endeavor.

Bonita L. Kincade, M.A.

Describe the population you usually see from school referals.

Primary Diagnosis _____

Age Range _____

Level of Functioning _____

_____

Type of Facility Child is in _____

_____

Do you require written background information from the school setting?

YES NO

Do you require written background information from the parents?

YES NO

Do you require any interviews prior to seeing the child?

YES NO

If YES, briefly explain:

Are the majority of parents cooperative?

YES NO

Are the majority of teachers cooperative?

YES NO

Do you receive requests for concrete suggestions for the family to implement in the home?

YES NO

Is your evaluation report supplemented with concrete suggestions for the school to implemnt through the child's I.E.P.?

YES NO

If NO, do the schools ever request such suggestions?

YES NO

Please include any comments you feel would make this questionnaire more insightful. Once again, thank you for taking the time out of your busy schedule to complete this.

Bonita L. Kincade, M.A.
Department of Psychiatry

APPENDIX B

RESULTS OF MENTAL HEALTH PROFESSIONAL QUESTIONNAIRE

RESULTS OF MENTAL HEALTH PROFESSIONAL QUESTIONNAIRE

TOTAL NUMBERED SURVEYED: 15

BREAKDOWN:
- Child Psychiatrist: 5
- Residents : 5
- Psychologists
  - Hospital: 1
  - School: 3
  - Clinical: 1

(1) Describe the population you service by primary diagnosis, age, level of functioning, and type of facility.

Primary diagnosis:		Age:		Type of Facility:	
SED	6	2.6-adult	11	Special Ed. class	11
MR	2	11-19	2	Regular class	2
Dual diagnosis	2	5-21	2	Hospital	2
trauma	1				
various cognitive dysfunctions	2				
mixture	1				

(2) Do you require any written background from the school setting.

YES 11 NO 4

(3) Do you require any written background from the parents.

YES 10 NO 5

(4) Do you require an interview prior to seeing the child.

YES 0 NO 10
(5 said very occassionally

(5) Are the majority of parents cooperative.

YES 10 NO 0 N/A 5

(6) Are the majority of teachers cooperative

YES 11 NO 0 N/A 4

(7) Do you receive requests for concrete suggestions for implementation in the home.

YES 0 NO 15

Is your evaluation report supplemented with concrete suggestions for the school to implement through the child's IEP.

YES 0 NO 15

APPENDIX C

QUESTIONNAIRE SENT TO
EDUCATION PROFESSIONALS

This questionnaire is being used to assess the needs of teachers working with students who have some degree of cognitive dysfunction. Specifically, it addresses the issues of the relationship of the results of an evaluation and its significance to the school setting. Please take a few minutes to carefully answer these questions. Feel free to add your own comments as you go along. The results will be used as a major resource in the designing of a training seminar for residents/interns in this field. Thank you for your expertise in this most timely endeavor.

Bonita L. Kincade, M.A.

Describe the population you service.

primary diagnosis _____
(i.e., MR, SED, CHI, etc.)

age and level _____

type of facility _____
(i.e., self-contained classroom, hospital, mainstreamed class, etc.)

What percentage of your students are refered for evaluations/testing?

100% 75% 50% 25% less than 25%

Are the parents and/or teachers requested to fill out any formal questionaires, or forms prior to the child's testing?

YES NO

Are the parents and/or teachers interviewed on an informal or formal basis prior to the child's testing?

YES NO

Are the parents and teachers furnished any written feedback concerning the results?

YES NO

Are concrete suggestions sent home to the families to facilitate the implementation of the evaluation findings?

YES NO

BRIEFLY EXPLAIN:

IS THERE FOLLOW-UP?

Is the evaluation report supplemented with educational methodologies to be implemented in the teaching setting/I.E.P. of the child?

YES NO

BRIEFLY EXPLAIN:

Are the results verbally interpreted, by the examiner, to the teaching staff in order to facilitate a clear understanding of the findings?

YES NO

BRIEFLY EXPLAIN:

On the average, how would you rate the results of the evaluations in regard to its practical and functional significance to the school setting?

EXCELLENT VERY GOOD GOOD AVERAGE FAIR POOR VERY POOR

BRIEFLY EXPLAIN:

Please include and comments not covered in the above questions. Once again, thank you for taking the time out of your busy schedule to complete this questionnaire..

Name _____

Address of work facility

_____

_____

Phone number of facility

_____

Bonita L. Kincade, M.A.
Deaprtment of Psychiatry

APPENDIX D

RESULTS OF
EDUCATION PROFESSIONALS
QUESTIONNAIRE

RESULTS OF EDUCATIONAL PROFESSIONALS QUESTIONNAIRES

TOTAL NUMBER SURVEYED: 56

BREAKDOWN: Intermediate Unit teachers: 45
Rehab Hospital teachers: 3
Private sp. ed. school: 8

(1) Describe the population you service.

Primary diagnosis:		Age:		Level of Functioning:	
SED	12	0-4	5	Wide range	56
MR	2	5-21	39		
CHI	3	8-11	3		
multi	15	2.6-21	3		
		14-21	6		

(2) What percentage of your students are refered for evaluations.
100% 56

(3) Are parents and/or teachers requestd to fill out any formal questionnaires prior to the child's testing.
100% 56

9$0 Are parents and/or teachers interviewed on an informal or formal basis prior to the child's testing.
YES 56 NO 0

(5) Are the parents or teachers furnished any written feedback concerning the results.
YES 56 NO 0
written evaluations are sent to the schools

(6) Are concrete suggestions sent home to the families for implementation of the evaluation findings.
YES 0 NO 56
teachers send home ideas but not as a result of the testing

(7) Is the evaluation report supplemented with educational methodologies to be implemented in the teaching setting/IEP planning.
YES 0 NO 56

(8) Are the results verbally interpreted, by the examiner, to the teacher in order to facilitate a clear understanding of the findings.
YES 8 NO 48

(9) On the average, how would you rate the results of the evaluations in regard to its practical and functional significance to the school setting.
AVERAGE 45 FAIR 3 POOR 8

APPENDIX E

PRE & POST TEST
IN-SERVICE SEMINAR

FILL IN THE BLANKS

1. An Individual Education Plan (IEP) clearly outlines instructional _____ and related _____ and materials working with a specific child.

2. To be instructionally relavant, assessment must serve dual roles of determining _____ and _____ developmental status.

3. The linkage procedure operates on the assumption that there must be an essential similarity between the behaviors _____ and the skills _____.

4. The process of _____ refers to the use of objectives and methods that are increasingly more normal or typical.

5. Assessment should be a functional "_____".

6. An objective of this seminar is emphasizing the critical importance of _____ between diagnosis and intervention.

TRUE OR FALSE

7. It is important to highlight the area of "primary disability" (i.e., mental retardation, emotional disturbance). T F

8. It is important to emphasize the complex set of interactions between developmental and learning disabilities. T F

9. In an assessment report that is specific with respect to a child's actual behaviors (strengths and deficits) it can be used to pinpoint instructional targets within a program curriculum. T F

10. The IEP is actually a tangable product of the linkage system.
T F

TOTAL OF CORRECT RESPONSES _____

PRE/POST TEST

APPENDIX F

FUNCTIONAL APPROACH CHECKLIST

FUNCTIONAL APPROACH CHECKLIST

Functional descriptors used for individual's capabilities
Y N

Functional descriptors used for limitations
Y N

Functional analyses of the child's range of developmental capabilities included
Y N

Functional analyses are adapted to the child's handicap
Y N

Evaluation is formative (constructive, practical, inferential)
Y N

Evaluation is summative (cumulative, additory, chain)
Y N

Assessment of dysfunctions cross functional domains
Y N

APPENDIX G

MECHANICISM FOR RECORDING UNEXPECTED EVENTS

LOG

OBJECTIVE #1

ALL CHILD PSYCHIATRIC STAFF IN TRAINING WILL INCREASE THEIR KNOWLEDGE OF THE EDUCATION PROGRAM BY RESPONDING TO 8 OUT OF 10 ITEMS ON THE POST TEST TO BE DEVELOPED BY THIS WRITER.

WEEK	ON TASK?	OFF TASK?	WHAT NEEDS TO BE DONE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

LOG

OBJECTIVE #2

ALL CONSULTATION REPORTS WILL INDICATE INCLUSION OF ALL COMPONENTS OF THE FUNCTIONAL APPROACH CHECKLIST TO BE DEVELOPED BY THIS WRITER. THE REPORT WILL BE CHECKED BY THE SUPERVISING PSYCHIATRIST BEFORE BEING SENT OUT.

WEEK	SUCCESSFUL	UNSUCCESSFUL	NEEDED CHANGE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

APPENDIX H
OUTLINE OF
SEMINAR LECTURE

SEMINAR OUTLINE

INTRODUCTION
. who are these kids
. what are we assessing
. why
. schools and curriculums
. gap between child assessment and programming
. overview of causal analysis from Chapter 2 of Proposal

TERMINOLOGY
. overhead sheet #1

ASSESSMENT
. developmental diagnosis - composition, specific process of analyzing, describing and profiling each child's range of developmental skills across multibehavioral areas
. multimeasure, multisource approach
. combine traditional scales, curriculum measures, behavior ratings and subjective judgements
. influence of Valet (1972) and Haeussermann (1958)

PURPOSE AND OBJECTIVES
. overhead sheet #2
. making decisions about a child's capabilities as they affect the nature of child's educational program
. overhead sheet #3
. review 4 points - sequenced and that each serves as a pre-requisite for the succeeding one, thus they are interdependent operations
. establishing linkage to programming

DEVELOPMENTAL MEASURES
. overhead sheet #4

ADAPTIVE STRATEGIES IN ASSESSMENT
. overhead sheet #5 and #6

MERGER OF ASSESSMENT AND CURRICULUM
. overhead sheet #7

A PRACTICAL SYSTEM FOR DESIGNING DEVELOPMENTAL LINKAGE
. overhead sheet #8

Goal 1. Selecting developmental scales according to curriculum content
. based on congruence with tasks in curriculum

. helpful if matchbetween assessment content and instructional content at each level of curriculum
. ensure conprehensive sampling of all behaviors
. overhead sheet #9 illustrates how combinations of child performance, teaching judgement, and curriculum measures can provide comprehensive coverage of developmental functioning at both general and specific levels of curriculum
. allows a more complete and accurate appraisal
. takes into account various skills that are situation-specific and therefore not necessarily evident in structured assessment situations

Goal 2. Determining developmental levels across functional areas
. comprehensive developmental analysis can be achieved
. most developmental scales sample both general developmental domains and various specific tasks comperable to those included in most curricula
. administration of norm-referenced developmental scales is useful for specifying a general developmental range/level
. identifys handicapped child's range and pattern
. overhead sheets #10 #11 illustrate how norm-referenced developmental diagnisis operates when it is curriculum- based and multisource in nature
. proceed from general to specific

Goal 3. Identify developmental ceilings in each functional area
. creation of sets of curriculum target objectives depends on the criterion-based use of traditional developmental scales
. this is a point at which your expertise can be invaluable to the special education professional in initial IEP planning
. criterion-based utility of most developmental scales is frequently overlooked
. identify a child's developmental ceiling in each area of functioning (highest point of developing skills)
. transitional level occuring within the developmental ranges determined in Goal 2
. specifies a range of absent or emerging functional skills that are practically viewed
. overhead sheet #12 shows handicap-appropriate developmental targets are provided by the developmental linkage process

Goal 4. Match developmental ceiling tasks to curriculum objectives in each functional areas
. no clear one-to-one correspondence relationship is apparent between all assessment ceilings and all objectives in a curriculum
. developmental basis of similar test and curriculum tasks across all areas allows many entry linkages to be selected at some point in the developmental task analysis
. developmental linkages accomplished simply by matching those test tasks that were failed (-) or partially completed ($\pm$) to congruent curriculum objectives included within child's current range of functioning

. discuss examples on overhead sheet #8
. outcome is creation of a set of individually appropriate curriculum-entry objectives across all functional areas for each child
. overhead sheet #13 compares the common developmental areas on various preschool scales and curricula

CASE STUDY

INITIAL SCREENING
. overhead sheet #13A
. screening and assessment linkages and I.E.P.
. overhead sheet #14
. teachers sequence record is an outline of the major steps in the diagnostic-perscriptive model and carefully designed to follow the guidelines of P.L. 94-142
. with practice, the steps described will become almost automatic

COMMUNITY SETTING
. factory town - Julian
. union established preschool
. spanish speaking neighborhood

THE IDENTIFICATION PROCESS - ALBERTO
. initial data collection
. behavior charting and graphing
. overhead sheets #15 and #16
. data comparison
. overhead sheets #17 and #18

THE HOME VISIT ARRANGED AND COMPLETED
. one hour meeting with mother
. Denver Developmental Screening Test (DDST)
. overhead sheet #19

PERMISSION FOR DIAGNOSTIC TESTING
. overhead sheet #20

REQUEST TO OUTSIDE AGENCIES
. overhead sheet #21

DIAGNOSTIC TESTING
. use of the Learning Accomplishment Profile - Diagnostic Edition (LAP-D)
. overhead sheet #22

DIAGNOSTIC TEST SCORES SUMMARIZED
. graph of results
. overhead sheet #23

OUTSIDE-AGENCY INFORMATION COMPILED
. overhead sheets #24 and #25

THE DECISION MODULE 1

STAFF RECOMMENDATIONS TO PARENTS
. Alberto remains in present program
. teachers and parents:
a) design remedial activities
b) determin data-collection method
. complete evaluation done by school district - if score comperable to LAP-D, he would be eligible for special education services

PARENT CONFERENCE ARRANGED
. data presented and discussed
. overhead sheet #26
. areas of concern are Verbal Expression and Self-Help Dressing Skills
. teacher identifies idems missed on LAD-D and links them to school curriculum (HICOMP)

LINKAGE DESCRIBED
. overhead sheets #27, #28, #29
. example:

LAP-D TASK	HICOMP Curriculum Target
FM 23 Initates bridge	M-3-2.5 Builds bridge of 3 cubes, imitating model

HICOMP LESSON PLAN CHART
. overhead sheets #30 and #31
. chart serves as a reminder that a developing child requires a balanced "diet" of objectives to ensure development across all major domains and subdomains

EVALUATION CONDUCTED
. Gesell Developmental Schedules
. overhead sheets #32 and #33

DEVELOPMENTAL NORM-REFERENCED EVALUATION
. summary report
. overhead sheets #34 and #35
. eligable for special education services

DECISION MODULE 2
PERSCRIPTION DECIDED

I.E.P. CONFERENCE
. iep's only describe remedial perscriptions
. objectives are not included in areas where the child exhibits developmentally predicted or above predicted behaviors

SCHOOL-HOME EXCHANGE AND RE-EVALUATION
. language development in the home
. overhead sheet #36
. progress notes
. overhead sheet #37

PROGRAM PLACEMENT DECIDED
. the I.E.P.
. overhead sheets #38, #39, #40, #41, #42, #43

FUNCTIONAL APPROACH CHECKLIST
. overhead sheet #44
. review of checklist
. how it is to be used

EVALUATION
. form to be distributed 1/10/88 and returned 1/14/88
. meeting set ofr 1/15/88

DISCUSSION AND QUESTIONS

APPENDIX I
OVERHEAD PROJECTOR SHEETS
TO ACCOMPANY LECTURE

TERMINOLOGY

ASSESSMENT REPORT

CAPABILITY TARGETS

CURRICULUM

DEVELOPMENTAL ASSESSMENT

FUNCTIONAL DESCRIPTIONS

I.E.P.

INTERVENTION

LINK INDEX

MEASURABLE

OBSERVABLE

P.L. 94-142

PRIMARY DISABILITY

PROGRAM PLACEMENT

#1

THE PURPOSE OF ASSESSMENT

1. screening and identification

2. assessing child capabilities comprehensively

3. designing individualized instructional plans

4. monitoring child progress and program effectiveness

#2

5 MAJOR OBJECTIVES

1. Assessment is embedded with instructional planning.

2. Similarity is ensured among behaviors assessed and behaviors taught.

3. Functional analyses of each child's range of developmental capabilities are provided, adapted to the child's handicap.

4. Multiple sources for monitoring skill acquisition are provided.

5. Both formative and summative evaluation of developmental progress is facilitated.

#3

DEVELOPMENTAL MEASURES

Designing procedures for assessing and programming for handicapped children is a complex procedure necessitating a multimeasure, multisource clinical approach. Measures must be selected that are DEVELPMENTAL in nature and serve to LINK the processes of comprehensive assessment and individualized goal-planning. The collection of both qualitative and quantitative data from norm-based, criterion-based, and adaptive sources facilitates this linkage. Simply, we must "test to the teaching."

#4

ADAPTIVE STRATEGIES IN ASSESSMENTS

1 Combine and group tasks within one or various instruments that tap certain behaviors or functional characteristics that you want to focus on in assessment.

* Memory span, form discrimination, receptive language skills catagorization and sequencing, auditory-visual discrimination.

2 Systematically alter the response mode required to function on and complete various tasks.

* Pointing vs. expresive language, headpointing vs. finger-pointing, eye localization vs. gesturing, steady child's hand on motor items.

3 Alter the method of evoking the response.

* Tasks requiring completion, fillin in, and elaboration through language changed to YES-NO, multiple-choice formats; use of pantomine directions and responses.

4 Omit task that you believe biased the results due to the child's handicapping conditions, and modify scoring criteria on selected items to accomodate child's persistence and behavior.

* Omit bead-stringing and block building activities for the C.P. child - eliminate times criteria on motor tasks, check for goal-direction, persistence, and quality of completion.

5 Decision to utilize nonverbal vs. verbal tasks for the language-impaired, C.P. and multiply handicapped child.

6 | Rearranging order of presentation of items within a test.

* Administer nonverbal items before verbal ones to facilitate establishment of rapport.

7 | Alter size and composition of objects and tasks within a test to accomodate child's limitations.

* Alter activities by using larger pictures, blocks, handles on formboards, or by rearranging order of pictures and their spacing; use of concrete and three dimensional objects rather than picture-symbolic items.

8 | Combine multiple measures that sample similar skills to increase reliability of results and scope of behavior samples.

9 | Use norm-referenced tasks in a criterion-referenced manner.

* TEST-TEACH-TEST MODEL. Give item in standardized way and note performance, then instruct child in the activity by highlighting relevant cues to the solution, reducing number of pictures on a card by covering up, asking focal questions, and using demonstration on the item; then administer the same or similar test to evaluate the effect and transfer of your instructional strategy.

10 | Task analysis and work-sample approach to assessment.

IN PRACTICE, THIS ADAPTIVE-PROCESS APPROACH IS A FUNCTIONAL EVALUATION METHOD THAT MERGES ASSESSMENT AND CURRICULUM ELEMENTS IN ORDER TO:

* DETERMINE FUNCTIONAL DEVELOPMENTAL LEVELS IN MULTIPLE AREAS
* IDENTIFY ALTERNATE METHODS OF RESPONDING
* DISCOVER THE CHILD'S TYPICAL STRATEGIES FOR PROBLEM SOLVING
* SELECT "ENTRY POINTS" TO GUIDE CURRICULUM PLANNING
* MODIFY TASKS TO COMPENSATE FOR FUNCTIONAL IMPAIRMENTS
* ARRANGE CHILD-MANAGEMENT STRATEGIES TO PROMOTE INDIVIDUAL DEVELOPMENTAL PROGRESS

#7

Outline Illustration of the Sequence of Steps in Creating Developmental Linkages

Goal 1. Select Developmental Scales According to Curriculum Content

Goal 2. Determine Developmental Levels Across Functional Areas

C.A. = 43 months.....	MOTOR	= 18-21 mo.
	ADAPTIVE	= 11-15 mo.
	LANGUAGE	= 9-12 mo.
	PERSONAL-SOCIAL	= 12 mo.

Goal 3. Identify "Developmental Ceilings" in Each Functional Area

Imitates common words	±
Speaks 3-4 words	-
Drinks cup-no spilling	±
Indicates wet pants	-
Jumps both feet	-
Attempts cube tower	-
Finds hidden objects	±
Goes to location	±

Goal 4. Match Developmental Ceiling Tasks to Curriculum Target-Objectives in Each Functional Area

TEST	CURRICULUM
Imitates common words.....	Imitates familiar words
Speaks 3-4 words.....	Uses words in speech
Drinks cup-no spilling.....	Drinks from cup-unassisted
Indicates wet pants.....	Gestures for wet pants and toilet
Jumps both feet.....	Jumps off floor/both feet
Attempts cube tower.....	Stacks two cubes
Finds hidden objects.....	Looks for object out of sight
Goes to location.....	Follows direction to go to location

An Example of Assessment Coverage at All Curriculum Levels via a Multimeasure, Multisource Approach

Suitable Tests	*HICOMP Curriculum Sequence*
PODS, Rating Scales	Motor Domain (year level 2-3) ..... (Domain Level)
PODS, PAR, DDST	M-3-2 Fine Motor ..... (Subdomain Level)
	M3-2.1 Draws circle, imitating adult ..... (Target Level)
	M3-2.2 Draws vertical line from model
BSID, BDS, LAP	M3-2.3 Draws horizontal line from model
Competency-based	M3-2.4 Draws recognizable face
curriculum checklists	M3-2.5 Builds bridge—3 cubes—imitated
	M3-2.6 Builds tower 9-10 cubes

PODS: Perceptions of Developmental Skills Profile—teacher judgments
PAR: Preschool Attainment Record—parent judgments
DDST: Denver Developmental Screening Test—general child performance
BSID: Bayley Scales of Infant Development—comprehensive child performance
GDS: Gesell Developmental Schedules—comprehensive child performance
LAP: Learning Accomplishment Profile—curriculum performance

An Example of Developmental Diagnosis Reflected in Congruent Assessment and Curriculum Domains

Child—C.A. = 43 mo.		Disability = Down's Syndrome	
Gesell Developmental Schedules (Ames et al., 1979)		*Project Memphis Curriculum*	
Personal-Social	15 mo.	Personal-Social	15 mo.
Gross-Motor	18-21 mo.	Gross-Motor	18 mo.
Fine-Motor	11-15 mo.	Fine-Motor	15 mo.
Language	9-12 mo.	Language	12 mo.
Adaptive	12 mo.	Perceptive-Cognitive	9 mo.

#10

An Example of Multimeasure Multisource Developmental Diagnosis

Child—C.A. = 43 mo. Disability—Down's Syndrome

Developmental Measures	*Level*	*Source*
Gesell Developmental Schedules (Ames et al., 1979)	12-15 months	Child Performance
Developmental Profile (Alpern & Boll, 1972)	18 months	Parent Judgment
Comp-Curriculum (Neisworth et al., 1980)	12 months	Curriculum Progress
Perceptions of Developmental Skills (Bagnato et al., 1977)	15 months	Teacher Judgment

#11

Assessment-Based Curriculum-Entry Targets

Child Michelle Curriculum

Test Gesell Developmental Schedules C.A. 34 months

	DEVELOPMENTAL CEILINGS		LINK INDEX	CURRICULUM-TARGET OBJECTIVES
	D.A. = 24(21-30) Mo.		COMMUNICATION	
±	Follows 2-4 simple directions			
±	Uses 20+ vocab. in speech			
–	Names pictures & objs 8-12			
±	Uses I, me, you & plurals			
±	Identifies objs & pictures			
–	Imitates 5-6 word phrase			
–	Gives full name-requested			
±	Answers personal/factual questions			
–	Combines 3-4 words in sent.			
±	Tells action & experiences			
±	Asks for food, toilet, drink			
–	Attends & listens to a story			
	D.A. = 21(18-24) Mo.		PROBLEM-SOLVING	
–	Matches ○□△shapes in puzzle			
–	Ident., match, sort colors			
±	Understands concept of "one"			
±	" prepositions & positions			
±	Imit. fine motor pen-drawing			
±	Names & ident. objects & pictures			
–	Imitates a sequence of blocks			
–	Repeats 2 digits imit. adult			
–	Folds paper imitates adult			
±	Identifies "big" & "small"			
–	Follows 2 simple directions			
–	Gives use of objects			

#12

Correspondence between Developmental Areas Common to Both Traditional Scales and Commonly Employed Preschool Curricula

	DEVELOPMENTAL SCALES				DEVELOPMENTAL PRESCHOOL CURRICULA			
AREA	GESELL	LAP	GRIFFITHS	BAYLEY	HICOMP	MEMPHIS	PORTAGE	DEVELOPMENTAL PROGRAMMING
LANGUAGE	Language	Language	Hearing and Speech	Mental	Communication	Language	Language	Language
PERSONAL/ SOCIAL	Personal/ Social	Social Self-help	Personal/ Social	Infant Behavior Record	Own-care	Personal/ Social	Self-help Socialization	Social/ Emotional Self-help
MOTOR	Gross & Fine Motor	Gross & Fine Motor	Eye-hand Coordination Locomotor	Mental/ Motor	Motor	Gross & Fine Motor	Motor	Perceptual/ Fine Motor Gross Motor
COGNITIVE	Adaptive	Cognitive	Performance Skills	Mental	Problem-solving	Perceptuo-Cognitive	Cognitive	Cognition

Teacher's Sequence Record

_____ Preschool/Child Care Center

Child's name _____ Birthdate _____

Activities	Date	Person(s) Involved
1.0 IDENTIFICATION PROCESS		
1.1 Initial data collection		
1.1.1 Charting and graphing		
1.1.2 Compare data to other records (e.g., The Denver Developmental Screening Test administered when child entered center)		
1.2 Home visit arranged		
1.3 Home visit conducted		
1.4 Parent(s) completes "Permission Form for Diagnostic Testing" and "Release of Information" Forms (e.g., Learning accomplish profile-diagnostic edition (LAP-D)		
1.5 Request to outside agency records if appropriate		
1.6 Diagnostic test administered		
1.7 Diagnostic test scores summarized (e.g., graph scores)		
1.8 Comparing screening and diagnostic test results:		
1.9 Outside agency information compiled		
2.0 DECISION MODULE I		
2.1 Staffing held to determine recommendations to parent(s)		
2.2 Parent conference arranged		
2.2.1 Who will attend		
2.2.2 Time/place		
2.3 Decision conference with parent(s)		
2.3.1 Data presented/discussed		
2.3.2 Options outlined		
☐ Continue in regular program with no remediations necessary: Link diagnostic test results (e.g., LAP-D) to curriculum (e.g., HICOMP)		
☐ Request norm-referenced developmental evaluation--parent signs permission form(s)		

#13A

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Activities	Date	Person(s) Involved
3.0 DEVELOPMENTAL NORM-REFERENCED EVALUATION		
3.1 Evaluation date/place arranged		
3.2 Evaluation conducted (e.g., Gesell Developmental Schedules)		
3.3 Team placement meeting: present: _____ _____ _____		
3.3.1 Placement discussed/ suggestions recorded		
3.3.2 Further referrals discussed/ suggestions recorded		
3.3.3 Prescriptions discussed/ suggestions recorded--ex.: Link test (e.g., Gesell) scores to curriculum e.g., HICOMP		
3.3.4 I.E.P. Conference arranged with staff and parent(s)		
4.0 DECISION MODULE II		
4.1 Prescriptions decided		
4.1.1 I.E.P. completed		
4.1.2 School/home information exchange		
4.1.3 Re-evaluation date(s) determined (e.g., repeated testing of Gesell, LAP-D		
4.2 Program placement decided		

#14

Baseline Data for Alberto's Verbal Expression

Name Alberto Arjona

Date August 11-15, 1980

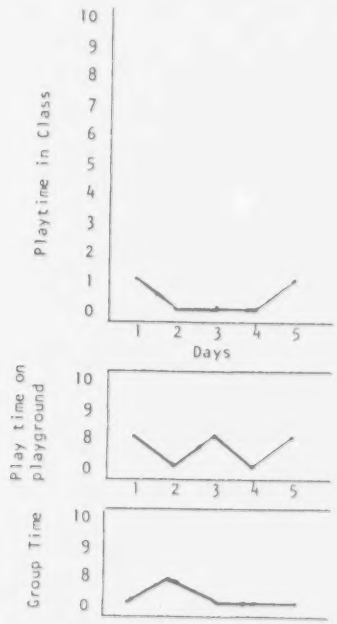
Data Collector Ms. Gibson

Behavior to Observe:

Conversation is defined as: Alberto initiating verbal expression to peer or teacher.
(Do not count responding to questions)

Length of Observation:

Play time in class - 15 minutes
Play time on playground - 15 minutes
Group time in class - 15 minutes



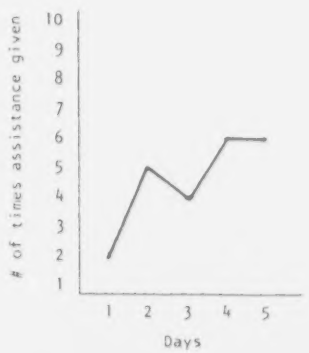
#15

Baseline Data on Alberto's Undressing/Dressing in the Bathroom

Name Alberto Arjona

Date August 11-15, 1980

Data Collector Ms. Gibson



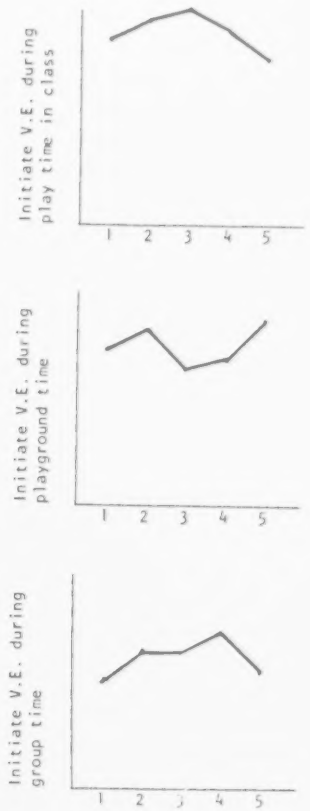
#16

Peer Comparison Baseline Data

Name Tomas

Date August 11

Data Collector Mrs. Gibson


Initiate V.E. during play time in class
1 2 3 4 5
Initiate V.E. during playground time
1 2 3 4 5
Initiate V.E. during group time
1 2 3 4 5

#17

Peer Comparison Baseline Data Dressing/Undressing

Name Tomas

Date August 11

Data Collector Mrs. Gibson

#18

ALBERTO'S TEST RESULTS

ON THE DENVER DEVELOPMENTAL SCREENING TEST

SOURCE: Frankenburg, W., Dodds, J. & Frandal, A., Denver Developmental Screening Test. Boulder, Colorado: Laudora Publishing Company., 1975.

#19

Permission Form for Diagnostic Testing of Alberto

Julian Preschool

Julian, PA

PERMISSION FOR INDIVIDUAL EVALUATION

Dear Mrs. _____:

We are requesting your permission to do an individual evaluation on your son/daughter Alberto. We intend to use the following test(s):

The Learning Accomplishment Profile Diagnostic Test (LAP-D)

_____

_____

The results of the test(s) will help us determine if Alberto is in need of any further evaluations. A parent conference will be scheduled to discuss the test(s) results.

Sincerely,

Mrs. Gibson
Teacher's Name

☑ I give permission for my child Alberto to receive further evaluation.

Mrs. Velma _____
Parent or Guardian Name

_____
Date

☑ I do not give permission for my child _____ to receive further evaluation.

_____
Parent or Guardian Name

_____
Date

#20

Permission Form for Requesting Other Agency Information about Alberto

Julian Preschool
Pennsylvania
August 18, 1980

Release of Information

Child's Name Alberto Birthdate June 18, 1977

Parent's Velma

Address 333 3rd Street

The Julian Preschool and Child Care Center have my permission to exchange information with the following persons and/or agencies concerning the above-named child. It is understood that this information will be used in the best interests of the child and will be held confidential.

Mrs. Velma
Parent/Guardian Signature

Mother
Relationship

Date

Note: Please include the name and address of any doctor/clinic, hospital, school, intermediate unit, or agency that could provide us with information concerning your child. Thank you.

Mrs. Gibson
Julian Preschool Representative

Name	Name
Address	Address
Phone	Phone

#21

ALBERTO'S PERFORMANCE

IN A LAP-D SUBDOMAIN

SOURCE: LeMay, D.W., Groffin, P.M., & Sanford, A.R. Learning Accomplishment Profile-Diagnostic Edition (Rev. Ed.). Winston-Salem, N.C.: Kaplan School Supply, 1978.

#22

GRAPH OF ALBERTO'S

LAP-D SCORES

SOURCE: From a graph suggested by E.Llewellyn for reporting LAP-D developmental ages.

#23

Letter from the State Health Center Regarding Alberto's Health History

State Health Center
101 North School Street
Pennsylvania 16210

Julian Preschool
Julian
Pennsylvania

Dear Ms. Gibson :

Alberto (birthdate 6/8/77) has attended our Child Health Conference (CHC) from September 19, 1977 for well-child check-ups and immunizations.

Alberto has received the following immunizations and tests through clinics:

DPT 10/1/77, 12/3/77, 2/4/78

Polio 10/1/77, 12/3/77, 2/4/78

Measles 6/26/78

Rubella 6/26/78

Tuberculin Test (Monovac) 5/5/78 neg.

Hematocrit 5/5/78 neg.

The following are the developmental milestones which you reported for Alberto's first eighteen months:

Eyes follow moving objects--attained at 2 months
Holds head erect--3 months
Reaches for a rattel--3 1/2 months
First tooth erupts--6 months
Rolls over--3 1/2 months
Sits alone--8 months
Creeps and pulls self to feet--11 months
Walks with support--11 months
Waves good-by (reported by mother)--18 months
Attempts self-feeding--12 months
Stands and walks alone--12 months

#24

continued

The following are Alberto's height, weight, and head circumference taken his first 18 months during CHC visits.

		WT.	HT.	Head circumference
06-18-77	Birth	7 lb. 6 oz.	19 in.	
10-01-77	3 1/2 mos.	13 lb. 14 oz.	23 in.	16 1/8 in.
11-05-77	5 mos.	15 lb. 6 1/4 oz.	24 1/4 in.	16 1/4 in.
12-03-77	6 mos.	16 lb. 1 1/2 oz.	25 1/4 in.	16 1/2 in.
02-04-78	8 mos.	18 lb.	26 in.	17 in.
05-05-78	11 mos.	19 lb. 8 oz.	27 1/2 in.	17 3/4 in.
06-02-78	12 mos.	20 lb. 6 1/2 oz.	29 in.	
12-01-79	18 mos.	22 lb. 12 oz.	30 in.	18 1/8 in.

Mr. has kept regular appointments with Alberto. With every CHC visit he seemed to have a medical problam (i.e., diarrhea and fever at 10/1/77 visit, rhinitis at 12/3/77, ear infections occurred frequently, a strept throat 11/3/78, 2/10/79 and 4/12/80.

Alberto will continue to be seen at CHC until he enters first grade. If we can be of further assistance, please call.

Sincerely,

Mary Mancuso

Mary Mancuso
Public Health Nurse

#25

Letter from Julian Area Medical Center Regarding Alberto's Health History

Julian Area Medical Center
Julian, Pennsylvania

August 20,

Julian Preschool/Day Care Center
Preschool Staff: Ms. Gibson

Dear Ms. Gibson:

We received your request for information about Alberto , who is being considered for possible inclusion by the Special Education Unit in Julian, Pennsylvania.

We have information mostly about acute illnesses such as colds, ear infections, sore throats, etc.

Alberto receives his well child care through the State Health Center. The Center's phone number is 535-3515.

Also, Gail Raisch, a social worker who is involved with the Home Health Service of Grove County, 512 High Street, Venice, Pennsylvania, phone 535-0012 would undoubtedly be of service to you for further information concerning the Arjona family.

If we could be of any further service to you, please feel free to contact us.

Very truly yours,

Diana Buckham

Diana Buckham
Nurse Practitioner

DB/jl

#26

Linkage of Alberto's LAP-D Scores with the HICOMP Curriculum

ASSESSMENT/CURRICULUM DEVELOPMENTAL LINKAGES

PRETEST 8/25/E

CHILD Alberto C.A. 38 months

TEST Learning Accomplishment Profile, LAP CURRICULUM HICOMP

DEVELOPMENTAL CEILINGS	LINK INDEX	CURRICULUM TARGETS
C.A. = 36 mo.	Fine Motor--Manipulation	
P-28 Imitates Bridge	M-3 - 2.5	Builds bridge of three cubes, imitating
P-29 Arrives through sewing board	M-3 - 2.3	Strings small beads ✓
P-30 Puts dots on pegboard	M-3 - 2.2	Places round pieces on round dots
C.A. = 42 mo.	Fine Motor--writing	
P-38 Imitates H strokes	M-3 - 3.3	Draws horizontal line 25 mm wide
P-39 Imitates V stroke	M-3 - 3.2	Draws vertical line 25 mm wide
P-40 Draws circle	M-3 - 3.1	Draws circle, imitating adult
C.A. = 30 mo.	Cognitive: Matching	
C-48 Matches animals	P-3 - 2.1	Solves match-to-sample problems ✓
C-49 Matches common patterns	M-3 - 3.4	Imitates a sequence of two behaviors
C-50 Matches object pictures	P-3 - 2.1	Solves match-to-sample problems
C.A. = 36 mo.	Cognitive: Counting	
C-52 Counts three cubes	P-3 - 4.1	Recognizes a model, reproduces a sequence of three objects ✓
C-53 Counts six beads	P-3 - 4.2	Recognizes a model, reproduces a sequence of four non-linear objects
C-54 1-10 by rote	P-3 - 4.3	Counts 6-10 rote in correct sequence

✓ = will be working on this objective immediately.

#27

continued

ASSESSMENT/CURRICULUM DEVELOPMENTAL LINKAGES
Page 2

	DEVELOPMENTAL CEILINGS	LINK INDEX	CURRICULUM TARGETS	
D.A. = 24 mo.		Language: Naming		
LN5	Names sex body parts	C-2 - 2.12	Uses 50 words	✓
LN6	Names use of objects	C-3 - 3.7	Responds with a word when asked, "What you doing?" "What's this?"	✓
LN7	Names objects by use	C-2 - 2.9	Identifies actions, uses verbs to describe and specifies names	
			(50?) objects and events	
D.A. = 24 mo.		Language: Comprehension		
LC8	Follows three (related) commands	C-2 - 3.13	Remembers and corrects connectes two simple related directions	
LC10	Responds to two prepositions	P-3 - 4.8	Locates possession names after 2 trials	
LC11	Follows two-step command	P-2 - 3.10	Remembers and corrects connectes two simple related directions	✓
D.A. = 35 mo.		Motor: Body Movement		
GB19	Bounces one foot, 5 seconds	M-3 - 1.9	Stands on one foot, momentarily	
GB22	Walks on a line	M-3 - 1.7	Walks on line on floor	
GB23	Squats	M-2 - 1.9	Squats in play two-three minutes	✓
D.A. = 36 mo.		Motor: Object Movement		
GO16	Catches bounced ball with arms	M-4 - 1.6	Catches bouncing ball, holding it against body	

#28

continued

ASSESSMENT/CURRICULUM DEVELOPMENTAL LINKAGES
Page 3

DEVELOPMENTAL CEILINGS		LINK INDEX	CURRICULUM TARGETS	
D.A. = 33 mo.		Self-Help: Eating		
	Over age for the items in	0-3 - 4.5	Blows in a controlled stream of air	✓
	this subdomain as range is	0-3 - 4.6	Removes food from spoon with upper lip	
	wide 13 months. Began at			
	33 month level.			
D.A. = 24 mo.		Self-Help: Dressing		
SD9	Puts on T-shirt	0-2 - 5.7	Finds garment holes and puts arms in (e.g., shirt)	✓
SD10	Unbuttons large button	0-3 - 5.2	Attempts unbuttoning a button	
SD11	Zips zipper	0-3 - 5.7	Independently zips a zipper	
D.A. = 42 mo.		Self-Help: Grooming		
	Connected all items in this	0-3 - 2.9	Attempts to brush teeth	✓
	subdomain which has a range	0-3 - 3.10	Brushes and combs hair	
	of 42 months. Began at	0-3 - 3.11	Attempts to use handkerchief when [illegible]	
	42 month level.			
D.A. = 36 mo.		Self-Help: Toileting		
ST7	Pulls down pants unassisted	0-3 - 5.7	Puts on and removes elasticized pants with assistance	
D.A. = 36 mo.		Self-Help: Self-Direction		
	Connected all items in this	0-3 - 1.1	Follows a simple rule concerning eating behaviors (e.g., "Please")	✓
	subdomain in which has a	0-3 - 1.7	Enjoys demonstrating and verbalizing [illegible]	
	range of 12 months.		[illegible]	

#29

HICOMP Lesson Plan Chart Showing 21 Teaching Objectives

#30

HICOMP LESSON PLAN CHART

	HICOMP 21 SUBDOMAINS	CODE	HICOMP 21 OBJECTIVES
	LANGUAGE RELATED PLAY	C-[2]-1.[2]	*Initiates a game (e.g., starts "pat-a-cake").*
✓	SELF EXPRESSION	C-[2]-2.[02]	*Uses 50 words.*
✓	LANGUAGE RESPONDING	C-[3]-3.[7]	*Responds with a verb when asked, "What are you doing?" e.g., "I'm washing the dishes."*
	IMITATION RELATED TO LANGUAGE	C-[2]-4.[6]	*Imitates speech reliably.*
	LANGUAGE RELATED ATTENTION	C-[2]-5.[7]	*Attends to longer verbalizations when they are accompanied by frequent descriptive actions.*
✓	MEETING SOCIAL CONVENTIONS AND DEVELOPING VALUES	O-[3]-1.[4]	*Follows a simple rule concerning eating behavior: e.g., saying "please, more milk."*
✓	HEALTH, SAFETY, AND PERSONAL CLEANLINESS	O-[3]-2.[9]	*Attempts to brush teeth.*
	AFFECTIVE REACTIONS TO ENVIRONMENT	O-[2]-3.[5]	*Approaches other children.*
✓	EATING AND DRINKING	O-[3]-4.[5]	*Blows in a controlled stream of air.*
✓	DRESSING/UNDRESSING	O-[2]-5.[7]	*Finds garment holes and puts limb in (e.g., arms).*
✓	GROSS MOTOR	M-[2]-1.[9]	*Squats in play 2-3 minutes.*
	FINE MOTOR	M-[3]-2.[6]	*Draws recognizable face.*
	ORAL	M-[3]-3.[5]	*Blows in controlled stream of air (e.g., blows bubbles).*

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ATTENTION	P-[3]-1-[5]	Engages in play or games for increasing lengths of time for number of tasks) prior to reinforcement.
IMITATION	P-[2]-2-[3]	Imitates a combination of a motor and speech when given the signal "(child's name), do this."
✓ RECALL	P-[2]-3-[10]	Remembers and correctly completes two simple related directions.
✓ CONCEPT FORMATION	P-[3]-4-[4]	Solves match-to-sample problems.
GROUPING	P-[2]-5-[3]	Shares divisible items [e.g., gives 1/2 cracker to peer during snack time].
✓ SEQUENCING	P-[3]-6-[1]	Following a model, reproduces a sequence of three items.
APPLICATION OF PRINCIPLES	P-[3]-7-[1]	Labels objects based on verbal information given.
CREATIVITY	P-[2]-8-[3]	Demonstrates a sense of humor.

✓ = Specific objectives from Assessment-Curriculum Developmental Linkages

#31

ALBERTO'S TEST RESULTS FROM

THE GESELL DEVELOPMENTAL

SCHEDULES

SOURCE: Ames, L.B., Gillespie, C., Haines, J., & Illg, F. Geselle Developmental Schedules (revised). Lumberland, Pa.: Geselle Institute for Human Development Book Service and Programs for Education, 1980.

#32 and #33

Summary of Test Results for Alberto on the Gesell Developmental Schedules

Name: Alberto .

DOT 9/10/8
DOB 6/18/77
CA 3 yr. 3 mo.

Assessment Instrument: Gesell Developmental Schedules

Alberto, age 39 months, was assessed for the dual purpose of determining his developmental capabilities and specifying an appropriate educational placement and educational objectives for him in the present school year.

Throughout the testing sessions within this evaluation, Alberto was cooperative but did not initiate any conversations with the examiner. Alberto was administered the items first in English and then in Spanish. The addition of the Spanish translation did not affect his scores on the individual items.

Results and Analysis

In the gross motor subdomain, Alberto demonstrated the ability to walk on tiptoe two or more steps, attempted to skip, stood on one foot over two minutes, jumped down from a small chair and landed on both feet, and hopped on one foot. Alberto was unable to walk up stairs with alternating feet. In the gross motor subdomain, Alberto was within the expected range for his chronological age.

In the fine motor subdomain, Alberto built a tower with ten cubes, drew pictures while holding a crayon by his fingers. He was unable to place ten pellets into a small bottle in the prescribed time of 23 seconds. Alberto's overall development in the motor domain lies between the 36 and 52 month maturity levels and is within chronological age expectations.

In the communication domain, Alberto is reported to typically not initiate conversation in either English or Spanish. Alberto gave his first name and sex when requested in English, he also correctly named seven pictured vocabulary cards. To all other requests which required

continued

a verbal response Alberto gave no answer. His development in the communication domain lies between the 24 and 30 month maturity levels and is significantly below chronological age expectations.

In the own care domain, Alberto is reported to feed himself with little spilling and to be toilet trained. Alberto consistently, by report of his teacher, and his examiner's observations could not undress or dress himself when he needed to use the toilet. On all items which tested dressing skills, Alberto refused to attempt except putting on his coat. His development in this domain lies between 36 and 42 months maturity levels. Albert's performance is only below his expected chronological age in the self dressing area.

In the problem solving domain, Alberto demonstrated the ability to complete the formboard inserting three blocks on presentation and in different positions, copied a cross with a crayon, and drew a man including three parts. Alberto did not perform any task which required verbal responses such as counting objects. This resulted in his level of development in the problem solving domain to be approximately at the 30 month maturity level which is below chronological age expectations.

Alberto appears to be developing normally in the motor and own care domain. Alberto's lack of skills in dressing himself should be explored further with his mother to determine if he is expected to take any responsibility in dressing himself in the home setting. Alberto's main delay at this time lies in the communication domain which also affects negatively his overall scores in the problem-solving domain. Specific language stimulation for use in the classroom is recommended. A structured preschool placement for the 1980-1981 school year is warranted for the specific purpose of developing his speech and language skills.

Melissa Moller
Special Education Unit School Psychologist

#35

Follow-Up Recommendations for Home Language Development for Alberto

FOLLOW UP RECOMMENDATIONS FOR HOME LANGUAGE DEVELOPMENT

1. Encourage Alberto to make verbal requests rather than gestures when he wants something.
2. Model the verbal request and then ask Alberto to repeat it. Please don't expect perfection the first trial, but do listen carefully that each trial is better than the previous.

   E.G.: Alberto points to cookie
   Mother: "Do you want a cookie?"
   Alberto shakes head, yes.
   Mother: say "cookie"
   Alberto says "cookie"
   Mother smiles, gives Alberto the cookie

   At the second trial . . .
   Alberto says "cookie"
   Mother says "Do you want a cookie?"
   Alberto says "cookie"
   Mother: "Alberto, say, 'want a cookie.'"
   Alberto says "Want a cookie."
   Mother smiles and gives Alberto the cookie

3. Spend ten minutes a day looking at children's books, magazines, or at items in and around the house, or community. Identify and describe the items and then ask Alberto to do it.

   E.g.: Mother: "Look at this tree."
   "say 'tree."
   Alberto says "tree."
   Mother: "See the pretty green leaves."
   Alberto: "leaves"

   Begin with objects or items that Alberto is very familiar with and then gradually bring in items that are not readily available in the environment.

#36

Sample Notes to the Home Regarding Alberto's Progress

Wk 1 Alberto is working on zipping and unzipping. This week, please unbuckle and unsnap Al's pants, take his hand, place it on the zipper and guide the zipper down. Then allow him to pull his pants down and later up. Place your hand on his, grasp the zipper catch and zip the zipper. Then snap and buckle without Alberto.

Wk 2 Dear Mrs. :

fastener - ZIPPER

Alberto's task - UNZIP-ZIP without assistance

Your task - unbuckle-buckle (belt)

unsnap-snap (pants)

verbal prompt ("put your hand on the zipper." etc.)

#37

Alberto's Individual Educational Plan

INDIVIDUAL EDUCATIONAL PLAN

09
Case Number

PROGRAM ELIGIBILITY

School Year

Present Developmental Levels

Cover Sheet

IU 3209

Name: Alberto
Preschool Teacher: Ms. Gibson
Itinerent Teacher: Mr. Zook

Birthdate: 6 /18 /77
Date Prepared: 10 /28 /8.
Prepared by: Ms. Gibson, Mr. Zook, Mrs. Escovar, Dr. McGlynn, and Mrs. Arjona

I. Individual Psychological Examination

Gesell--A normed-referenced developmental evaluation

II. Parental Input

Home Visits
Conference

III. Medical Confirmation

Medical Records Complete
No Problems

IV. Educational Assessment

Denver--Developmental Screening Test
LAP-D--Criteria-referenced developmental evaluation

V. Other

Teacher Observations

Recommended for Special Program ☑
Not Recommended for Special Program ☐

Language Therapy in the Julian Center

Comment:

#38

continued

Individual Educational Plan
Julian Preschool

Student's Name Alberto
Birthdate June 18, 1977
Present Date Oct. 28,

Program Julian Preschool
Teacher(s) Ms. Gibson

Primary Assignment	Date Started	Expected Duration	Special Media/Materials
Julian Preschool	Nov. 1, 19[illegible]	On Going	None

Extent to which the student will participate in Regular Preschool:
Alberto is involved in a regular preschool with itinerant special education services.

Services:

language therapist	Nov. 1., 1980	On going	None

IEP Planning Participants: Mrs. - Parent
Ms. Gibson - teacher
Mr. Zook - language therapist
Mrs. Escovar - teacher (bilingual)
Dr. Acklynn, Psychologist LEA Rep.

Dates for review and/or revision of the IEP Plan:

Person responsible for the maintenance and implementation of the IEP Plan: Ms. Gibson, Preschool teacher

#39

continued

Individual Educational Plan

Julian Preschool

Student's Name Alberto

Instructional Area(s) Problem Solving

Annual Goal(s) To increase on-task behavior

OBJECTIVES	INSTRUCTIONAL METHODS	EVALUATION PLAN and CRITERIA
Alberto will . . .		
a. engage in play/games for increasing lengths of time (or # of tasks) prior to reinforcement.	SHAPING	CHART DURATION OF A BEHAVIOR
b. attend during group "lessons" or activities for 5-10 minutes with some adult prompting.	SHAPING, PROMPTING ATTENTION, VERBAL PROMPTING, VISUAL PROMPTING	CHECKLIST with BEHAVIORAL RATING SCALE-- CHART DURATION OF A BEHAVIOR
c. persist at most age appropriate tasks (e.g., puzzles, art activity) until completion and with minimal prompts from adults	SHAPING	CHART DURATION OF A BEHAVIOR
d. attend for group activities of 10-15 minutes with little prompting from adults (e.g., story times, games circles)	SHAPING	CHART DURATION OF A BEHAVIOR

#40

continued

Individual Educational Plan

Julian Preschool

Student's Name Alberto

Instructional Area(s) Own Care

Annual Goal(s) dress/undress without assistance when using the toilet

OBJECTIVES	INSTRUCTIONAL METHODS	EVALUATION PLAN and CRITERIA
Alberto will . . .		
a. unzip and zip a zipper on pants.	SHAPING MODELING	USE OF A BEHAVIOR RATING CHECKLIST
b. unbutton and button a button on	VERBAL, MANUAL AND VISUAL PROMPTING	
c. unbuckle and buckle a buckle on belt.		Criteria
d. unsnap and snap a snap on pants.		cannot do it = 0 begins to try = 1 does it with help = 2 does much alone = 3 does it alone = 4
e. put on and remove elasticized pants.		Sample
f. put on and take off pants with snaps (or buttons) and zipper.		unzips 01234 zips 01234 unbuttons 01234

#41

continued

Individual Educational Plan

Julian Preschool

Student's Name Alberto

Instructional Area(s) Language Develooment

Annual Goal(s) To increase verbal experssion skills between peers and teachers.

	OBJECTIVE	STRATEGY	EVALUATION
a.	uses speech to attract attention of peer or caregiver	shaping	frequency of behavior
b.	names several objects	shaping, modeling	frequency of behavior
c.	makes one word requests	shaping, modeling	frequency of behavior
d.	expresses gratitude verbally	shaping, modeling	critical incidence method
e.	describes or designates an object	anecdotal record, modeling	frequency of behavior
f.	names, directs, or describes an action	modeling	frequency of behavior
g.	uses real two-word combinations	chaining behavior, modeling	frequency of behavior
h.	uses varied forms of word combinations (location, possession, nonexistence, negation, questions, action-recipient)	chaining behavior, modeling	frequency of behavior
i.	uses 50 words	modeling	frequency of behavior
j.	combines several parts of speech	chaining behavior, verbal prompting	frequency of behavior
k.	uses compound sentences	chaining behavior, verbal prompting	frequency of behavior
l.	ask 3-4 word questions	modeling, verbal prompting	frequency of behavior
m.	uses sentences of 4-8 words in length	chaining behavior, modeling	frequency of behavior
n.	shares (during conversation or show and tell), information about activities/events experienced	verbal prompting	simple yes-no statement

#42

continued

	OBJECTIVE	STRATEGY	EVALUATION
o.	retells stories of actual events or from books	verbal prompting	simple yes-no statement
p.	requests favorite activities or objects by asking complete questions or making statements of preference	verbal prompting	frequency of behavior simple yes-no statements
q.	uses staetements of over seven words in length	chaining behavior, modeling	frequency of behavior
r.	converses with other adults and children	chaining behavior, modeling	anecdotal record

APPENDIX J
SEMINAR HANDBOOK

There is a gap between assessment of children with cognitve dysfunctions and programming for them. Too often, assessment reports furnished to teachers are irrelevant or may only be remotely useful for designing individual educational programs.

Because of the mismatch between assessment and instructional activities, this seminar is an attempt to develop a straightfoward approach for linking these two important elements.

TERMINOLOGY

ASSESSMENT REPORT

CAPABILITY TARGETS

CURRICULUM

DEVELOPMENTAL ASSESSMENT

FUNCTIONAL DESCRIPTIONS

I.E.P.

INTERVENTION

LINK INDEX

MEASURABLE

OBSERVABLE

P.L. 94-142

PRIMARY DISABILITY

PROGRAM PLACEMENT

THE PURPOSE OF ASSESSMENT

1. screening and identification

2. assessing child capabilities comprehensively

3. designing individualized instructional plans

4. monitoring child progress and program effectiveness

5 MAJOR OBJECTIVES

1. Assessment is embedded with instructional planning.

2. Similarity is ensured among behaviors assessed and behaviors taught.

3. Functional analyses of each child's range of developmental capabilities are provided, adapted to the child's handicap.

4. Multiple sources for monitoring skill acquisition are provided.

5. Both formative and summative evaluation of developmental progress is facilitated.

DEVELOPMENTAL MEASURES

Designing procedures for assessing and programming for handicapped children is a complex procedure necessitating a multimeasure, multisource clinical approach. Measures must be selected that are DEVELPMENTAL in nature and serve to LINK the processes of comprehensive assessment and individualized goal-planning. The collection of both qualitative and quantitative data from norm-based, criterion-based, and adaptive sources facilitates this linkage. Simply, we must "test to the teaching."

ADAPTIVE STRATEGIES IN ASSESSMENTS

1 Combine and group tasks within one or various instruments that tap certain behaviors or functional characteristics that you want to focus on in assessment.

* Memory span, form discrimination, receptive language skills catagorization and sequencing, auditory-visual discrimination.

2 Systematically alter the response mode required to function on and complete various tasks.

* Pointing vs. expresive language, headpointing vs. finger-pointing, eye localization vs. gesturing, steady child's hand on motor items.

3 Alter the method of evoking the response.

* Tasks requiring completion, fillin in, and elaboration through language changed to YES-NO, multiple-choice formats; use of pantomine directions and responses.

4 Omit task that you believe biased the results due to the child's handicapping conditions, and modify scoring criteria on selected items to accomodate child's persistence and behavior.

* Omit bead-stringing and block building activities for the C.P. child - eliminate times criteria on motor tasks, check for goal-direction, persistence, and quality of completion.

5 Decision to utilize nonverbal vs. verbal tasks for the language-impaired, C.P. and multiply handicapped child.

6 | Rearranging order of presentation of items within a test.

* Administer nonverbal items before verbal ones to facilitate establishment of rapport.

7 | Alter size and composition of objects and tasks within a test to accomodate child's limitations.

* Alter activities by using larger pictures, blocks, handles on formboards, or by rearranging order of pictures and their spacing; use of concrete and three dimensional objects rather than picture-symbolic items.

8 | Combine multiple measures that sample similar skills to increase reliability of results and scope of behavior samples.

9 | Use norm-referenced tasks in a criterion-referenced manner.

* TEST-TEACH-TEST MODEL. Give item in standardized way and note performance, then instruct child in the activity by highlighting relevant cues to the solution, reducing number of pictures on a card by covering up, asking focal questions, and using demonstration on the item; then administer the same or similar test to evaluate the effect and transfer of your instructional strategy.

10 | Task analysis and work-sample approach to assessment.

IN PRACTICE, THIS ADAPTIVE-PROCESS APPROACH IS A FUNCTIONAL EVALUATION METHOD THAT MERGES ASSESSMENT AND CURRICULUM ELEMENTS IN ORDER TO:

* DETERMINE FUNCTIONAL DEVELOPMENTAL LEVELS IN MULTIPLE AREAS

* IDENTIFY ALTERNATE METHODS OF RESPONDING

* DISCOVER THE CHILD'S TYPICAL STRATEGIES FOR PROBLEM SOLVING

* SELECT "ENTRY POINTS" TO GUIDE CURRICULUM PLANNING

* MODIFY TASKS TO COMPENSATE FOR FUNCTIONAL IMPAIRMENTS

* ARRANGE CHILD-MANAGEMENT STRATEGIES TO PROMOTE INDIVIDUAL DEVELOPMENTAL PROGRESS

CASE STUDY

INITIAL SCREENING

THE COMMUNITY SETTING

THE IDENTIFICATION PROCESS

THE HOME VISIT

PERMISSION FOR DIAGNOSTIC TESTING

REQUESTS TO OUTSIDE AGENCIES

DIAGNOSTIC TESTING

DIAGNOSTIC TEST SCORES SUMMARIZED

OUTSIDE AGENCY INFORMATION COMPILED

THE DECISION MODULE 1

STAFF RECOMMENDATIONS TO PARENTS

PARENT CONFERENCE ARRANGED

THE LINKAGE DESCRIBED

EVALUATION CONDUCTED

DEVELOPMENTAL NORM-REFERENCED EVALUATION

DECISION MODULE 2

I.E.P. CONFERENCE

SCHOOL-HOME EXCHANGE AND RE-EVALUATION

PROGRAM PLACEMENT DECIDED

Outline Illustration of the Sequence of Steps in Creating Developmental Linkages

Goal 1. Select Developmental Scales According to Curriculum Content

Goal 2. Determine Developmental Levels Across Functional Areas

C.A. = 43 months.....	MOTOR	= 18-21 mo.
	ADAPTIVE	= 11-15 mo.
	LANGUAGE	= 9-12 mo.
	PERSONAL-SOCIAL	= 12 mo.

Goal 3. Identify "Developmental Ceilings" in Each Functional Area

Imitates common words	±
Speaks 3-4 words	-
Drinks cup-no spilling	±
Indicates wet pants	-
Jumps both feet	-
Attempts cube tower	-
Finds hidden objects	±
Goes to location	±

Goal 4. Match Developmental Ceiling Tasks to Curriculum Target-Objectives in Each Functional Area

TEST	CURRICULUM
Imitates common words.....	Imitates familiar words
Speaks 3-4 words.....	Uses words in speech
Drinks cup-no spilling.....	Drinks from cup-unassisted
Indicates wet pants.....	Gestures for wet pants and toilet
Jumps both feet.....	Jumps off floor/both feet
Attempts cube tower.....	Stacks two cubes
Finds hidden objects.....	Looks for object out of sight
Goes to location.....	Follows direction to go to location

Assessment-Based Curriculum-Entry Targets

Child Michelle Curriculum

Test Gesell Developmental Schedules C.A. 34 months

	DEVELOPMENTAL CEILINGS		LINK INDEX	CURRICULUM-TARGET OBJECTIVES
	D.A. = 24(21-30) Mo.		COMMUNICATION	
±	Follows 2-4 simple directions			
±	Uses 20+ vocab. in speech			
−	Names pictures & Objs 6-12			
±	Uses I, me, you & plurals			
±	Identifies objs & pictures			
−	Imitates 5-6 word phrase			
−	Gives full name-requested			
±	Answers personal/factual questions			
−	Combines 3-4 words in sent.			
±	Tells action & experiences			
±	Asks for food, toilet, drink			
−	Attends & listens to a story			
	D.A. = 21(18-24) Mo.		PROBLEM-SOLVING	
−	Matches ○□△shapes in puzzle			
−	Ident., match, sort colors			
±	Understands concept of "one"			
±	" prepositions & positions			
±	Imit. fine motor pen-drawing			
±	Names & ident. objects & pictures			
−	Imitates a sequence of blocks			
−	Repeats 2 digits imit. adult			
−	Folds paper imitates adult			
±	Identifies "big" & "small"			
−	Follows 2 simple directions			
−	Gives use of objects			

Teacher's Sequence Record

_____ Preschool/Child Care Center

Child's name _____ Birthdate _____

Activities	Date	Person(s) Involved
1.0 IDENTIFICATION PROCESS		
1.1 Initial data collection		
1.1.1 Charting and graphing		
1.1.2 Compare data to other records (e.g., The Denver Developmental Screening Test administered when child entered center)		
1.2 Home visit arranged		
1.3 Home visit conducted		
1.4 Parent(s) completes "Permission Form for Diagnostic Testing" and "Release of Information" Forms (e.g., Learning accomplish profile-diagnostic edition (LAP-D)		
1.5 Request to outside agency records if appropriate		
1.6 Diagnostic test administered		
1.7 Diagnostic test scores summarized (e.g., graph scores)		
1.8 Comparing screening and diagnostic test results:		
1.9 Outside agency information compiled		
2.0 DECISION MODULE I		
2.1 Staffing held to determine recommendations to parent(s)		
2.2 Parent conference arranged		
2.2.1 Who will attend		
2.2.2 Time/place		
2.3 Decision conference with parent(s)		
2.3.1 Data presented/discussed		
2.3.2 Options outlined		
☐ Continue in regular program with no remediations necessary: Link diagnostic test results (e.g., LAP-D) to curriculum (e.g., HICOMP)		
☐ Request norm-referenced developmental evaluation--parent signs permission form(s)		

Activities	Date	Person(s) Involved
3.0 DEVELOPMENTAL NORM-REFERENCED EVALUATION		
3.1 Evaluation date/place arranged		
3.2 Evaluation conducted (e.g., Gesell Developmental Schedules)		
3.3 Team placement meeting: present:_____		
3.3.1 Placement discussed/ suggestions recorded		
3.3.2 Further referrals discussed/ suggestions recorded		
3.3.3 Prescriptions discussed/ suggestions recorded--ex.: Link test (e.g., Gesell) scores to curriculum e.g., HICOMP		
3.3.4 I.E.P. Conference arranged with staff and parent(s)		
4.0 DECISION MODULE II		
4.1 Prescriptions decided		
4.1.1 I.E.P. completed		
4.1.2 School/home information exchange		
4.1.3 Re-evaluation date(s) determined (e.g., repeated testing of Gesell, LAP-D		
4.2 Program placement decided		

ALBERTO'S TEST RESULTS

ON THE

DENVER DEVELOPMENTAL SCREENING TEST

SOURCE: Frankenburg, W. Dodds, J. & Frandal, A. Denver Developmental Screening Test. Boulder, Colorado: Ladora Publishing Co., 1975.

ALBERTO'S PERFORMANCE

IN A LAP-D SUBDOMAIN

SOURCE: LeMay, D.W., Griffin, P.M. & Sanford, A.R. Learning Accomplishment Profile-Diagnistic Edition (Rev. ed.). Winston-Salem, N.C.: Kaplan School Supply, 1978.

Linkage of Alberto's LAP-D Scores with the HICOMP Curriculum

ASSESSMENT/CURRICULUM DEVELOPMENTAL LINKAGES

PRETEST 8/25/8

CHILD Alberto C.A. 38 months

TEST Learning Accomplishment Profile, LAP CURRICULUM HICOMP

DEVELOPMENTAL CEILINGS	LINK INDEX	CURRICULUM TARGETS
D.A. = 39 mo.	Fine Motor--Manipulation	
FM23 Imitates Bridge	H-3 - 2.5	Builds bridge of three cubes, imitating
FM26 weaves forearm sewing board	H-3 - 2.3	Strings small beads ✓
FM27 Puts peas on pegboard	H-3 - 2.9	Places round object in round hole
D.A. = 42 mo.	Fine Motor--Writing	
FW19 Imitates H stroke	H-3 - 2.3	Draws horizontal line from model
FW12 Imitates V stroke	H-3 - 2.2	Draws vertical line from model
FW13 Copies circle	H-3 - 2.1	Draws circle, imitating adult
D.A. = 39 mo.	Cognitive: Matching	
CM9 Matches animals	P-3 - 4.1	Solves match-to-sample problems ✓
CM10 Matches complex patterns	H-3 - 2.2	Imitates a sequence of two behaviors
CM11 Matches object pictures	P-3 - 4.7	Solves match-to-sample problems
D.A. = 39 mo.	Cognitive: Counting	
CC2 Counts three cubes	P-3 - 6.1	Follows a model, reproduces a sequence of three objects ✓
CC3 Counts six beads	P-3 - 6.2	Follows a model, reproduces a sequence of five objects
CC4 1-10 by rote	P-3 - 5.9	Counts by rote in correct sequence

✓ We will be working on this objective immediately.

continued

ASSESSMENT/CURRICULUM DEVELOPMENTAL LINKAGES
Page 2

DEVELOPMENTAL CEILINGS		LINK INDEX	CURRICULUM TARGETS	
D.A. = 24 mo.		Language: Naming		
LN5	Names six body parts	C-2 - 2.12	Uses 50 words	✓
LN6	Names use of objects	C-3 - 3.7	Responds with a word when asked, "What are you doing?"	✓
LN7	Names objects by use	C-4 - 2.9	Names 6 body parts and supplies names for objects and events	
D.A. = 24 mo.		Language: Comprehension		
LC6	Follows three (related) commands	C-2 - 3.13	Remembers and corrects connects two simple related directions	
LC12	Responds to two prepositions	P-3 - 4.3	Reveals location names after a delay	
LC11	Follows two-step command	P-2 - 3.10	Remembers and corrects connects two simple related directions	✓
D.A. = 36 mo.		Motor: Body Movement		
GB19	Balances one foot, 5 seconds	M-3 - 1.9	Stands on one foot, momentarily	
GB22	Walks on a line	M-3 - 1.7	Walks on line on floor	
GB23	Squats	M-2 - 1.9	Squats in play two-three minutes	✓
D.A. = 36 mo.		Motor: Object Movement		
GB16	Catches bounced ball with arms	M-4 - 1.6	Catches bouncing ball, holding it against body	

continued

ASSESSMENT/CURRICULUM DEVELOPMENTAL LINKAGES
Page 3

DEVELOPMENTAL CEILINGS		LINK INDEX	CURRICULUM TARGETS	
D.A. = 36 mo.		Self-Help: Eating		
	Over age for the items in this subdomain as range is only 18 months. Began at 36 month level.	0-3 - 4.5	Blows in a controlled stream of air	✓
		0-3 - 4.6	Removes food from spoon with upper lip	
D.A. = 24 mo.		Self-Help: Dressing		
SD9	Puts on T-shirt	0-2 - 5.7	Finds garment holes and puts limb in (e.g., arms)	✓
SD10	Unbuttons large button	0-3 - 5.2	Attempts unbuttoning a button	
SD11	Zips zipper	0-4 - 5.7	Independently zips a zipper	
D.A. = 42 mo.		Self-Help: Grooming		
	Connected set items on this subdomain which has a range of 42 months. Began at 32 month level.	0-3 - 2.9	Attempts to brush teeth	✓
		0-4 - 2.10	Brushes and combs hair	
		0-4 - 2.11	Attempts to use mirror when [illegible]	
D.A. = 33 mo.		Self-Help: Toileting		
ST7	Pulls down pants unassisted	0-3 - 5.7	Puts on and removes elasticized pants with assistance	
D.A. = 33 mo.		Self-Help: Self-Direction		
	Connected set items on this subdomain which has a range of 42 months.	0-3 - 1.4	Follows a simple rule concerning eating behavior: saying "please"	✓
		0-3 - 1.7	Enjoys demonstrating and practicing newly learned skills, e.g., puts on own coat zipper.	

ALBERTO'S TEST RESULTS

FROM THE

GESELL DEVELOPMENTAL SCHEDULES

SOURCE: Ames, L.B., Gillespie, C., Haines, J., & Ilg, F. Geselle Developmental Scheudles (revised). Lumberland, PA: Gesell Institute for Human Development Book Service and Programs for Education, 1980.

Summary of Test Results for Alberto on the Gesell Developmental Schedules

Name: Alberto

DOT 9/10/80
DOB 6/18/77
CA 3 yr. 3 mo.

Assessment Instrument: Gesell Developmental Schedules

Alberto, age 39 months, was assessed for the dual purpose of determining his developmental capabilities and specifying an appropriate educational placement and educational objectives for him in the present school year.

Throughout the testing sessions within this evaluation, Alberto was cooperative but did not initiate any conversations with the examiner. Alberto was administered the items first in English and then in Spanish. The addition of the Spanish translation did not affect his scores on the individual items.

Results and Analysis

In the gross motor subdomain, Alberto demonstrated the ability to walk on tiptoe two or more steps, attempted to skip, stood on one foot over two minutes, jumped down from a small chair and landed on both feet, and hopped on one foot. Alberto was unable to walk up stairs with alternating feet. In the gross motor subdomain, Alberto was within the expected range for his chronological age.

In the fine motor subdomain, Alberto built a tower with ten cubes, drew pictures while holding a crayon by his fingers. He was unable to place ten pellets into a small bottle in the prescribed time of 23 seconds. Alberto's overall development in the motor domain lies between the 36 and 52 month maturity levels and is within chronological age expectations.

In the communication domain, Alberto is reported to typically not initiate conversation in either English or Spanish. Alberto gave his first name and sex when requested in English, he also correctly named seven pictured vocabulary cards. To all other requests which required

continued

a verbal response Alberto gave no answer. His development in the communication domain lies between the 24 and 30 month maturity levels and is significantly below chronological age expectations.

In the own care domain, Alberto is reported to feed himself with little spilling and to be toilet trained. Alberto consistently, by report of his teacher, and his examiner's observations could not undress or dress himself when he needed to use the toilet. On all items which tested dressing skills, Alberto refused to attempt except putting on his coat. His development in this domain lies between 36 and 42 months maturity levels. Albert's performance is only below his expected chronological age in the self dressing area.

In the problem solving domain, Alberto demonstrated the ability to complete the formboard inserting three blocks on presentation and in different positions, copied a cross with a crayon, and drew a man including three parts. Alberto did not perform any task which required verbal responses such as counting objects. This resulted in his level of development in the problem solving domain to be approximately at the 30 month maturity level which is below chronological age expectations.

Alberto appears to be developing normally in the motor and own care domain. Alberto's lack of skills in dressing himself should be explored further with his mother to determine if he is expected to take any responsibility in dressing himself in the home setting. Alberto's main delay at this time lies in the communication domain which also affects negatively his overall scores in the problem-solving domain. Specific language stimulation for use in the classroom is recommended. A structured preschool placement for the 1980-1981 school year is warranted for the specific purpose of developing his speech and language skills.

Melissa Moller
Special Education Unit School Psychologist

BEST COPY AVAILABLE

Follow-Up Recommendations for Home Language Development for Alberto

FOLLOW UP RECOMMENDATIONS FOR HOME LANGUAGE DEVELOPMENT

1. Encourage Alberto to make verbal requests rather than gestures when he wants something.
2. Model the verbal request and then ask Alberto to repeat it. Please don't expect perfection the first trial, but do listen carefully that each trial is better than the previous.

   E.G.: Alberto points to cookie
   Mother: "Do you want a cookie?"
   Alberto shakes head, yes.
   Mother: say "cookie"
   Alberto says "cookie"
   Mother smiles, gives Alberto the cookie

   At the second trial . . .
   Alberto says "cookie"
   Mother says "Do you want a cookie?"
   Alberto says "cookie"
   Mother: "Alberto, say, 'want a cookie.'"
   Alberto says "Want a cookie."
   Mother smiles and gives Alberto the cookie

3. Spend ten minutes a day looking at children's books, magazines, or at items in and around the house, or community. Identify and describe the items and then ask Alberto to do it.

   E.g.: Mother: "Look at this tree."
   "say 'tree."
   Alberto says "tree."
   Mother: "See the pretty green leaves."
   Alberto: "leaves"

   Begin with objects or items that Alberto is very familiar with and then gradually bring in items that are not readily available in the environment.

Alberto's Individual Educational Plan

INDIVIDUAL EDUCATIONAL PLAN

09
Case Number

PROGRAM ELIGIBILITY

School Year

Present Developmental Levels

Cover Sheet

IU 3209

Name: Alberto
Birthdate: 6 /18 /77

Preschool Teacher: Ms. Gibson
Date Prepared: 10 /28 /6

Itinerent Teacher: Mr. Zook
Prepared by: Ms. Gibson, Mr. Zook, Mrs. Escovar, Dr. McGlynn, and Mrs. Arjona

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Gesell--A normed-referenced developmental evaluation

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Conference

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Medical Records Complete
No Problems

IV. Educational Assessment

Denver--Developmental Screening Test
LAP-D--Criteria-referenced developmental evaluation

V. Other

Teacher Observations

Recommended for Special Program ☑
Not Recommended for Special Program ☐

Language Therapy in the Julian Center

Comment:

continued

Individual Educational Plan
Julian Preschool

Student's Name Alberto
Birthdate June 18, 1977
Present Date Oct. 28, 198_

Program Julian Preschool
Teacher(s) Ms. Gibson

Primary Assignment	Date Started	Expected Duration	Special Media/Materials
Julian Preschool	Nov. 1, 198	On Going	None

Extent to which the student will participate in Regular Preschool:
Alberto is involved in a regular preschool with itinerant special education services.

Services:

language therapist	Nov. 1., 19f	On going	None

IEP Planning Participants: Mrs. - Parent
Ms. Gibson - teacher
Mr. Zook - language therapist
Mrs. Escovar - teacher (bilingual)
Dr. Tetzlaff, Psychologist LEA Rep.

Dates for review and/or revision of the IEP Plan:

Person responsible for the maintenance and implementation of the IEP Plan: Ms. Gibson, Preschool teacher

continued

Individual Educational Plan

Julian Preschool

Student's Name Alberto

Instructional Area(s) Problem Solving

Annual Goal(s) To increase on-task behavior

OBJECTIVES	INSTRUCTIONAL METHODS	EVALUATION PLAN and CRITERIA
Alberto will . . .		
a. engage in play/games for increasing lengths of time (or # of tasks) prior to reinforcement.	SHAPING	CHART DURATION OF A BEHAVIOR
b. attend during group "lessons" or activities for 5-10 minutes with some adult prompting.	SHAPING, PROMPTING ATTENTION, VERBAL PROMPTING, VISUAL PROMPTING	CHECKLIST with BEHAVIORAL RATING SCALE-- CHART DURATION OF A BEHAVIOR
c. persist at most age appropriate tasks (e.g., puzzles, art activity) until completion and with minimal prompts from adults	SHAPING	CHART DURATION OF A BEHAVIOR
d. attend for group activities of 10-15 minutes with little prompting from adults (e.g., story times, games circles)	SHAPING	CHART DURATION OF A BEHAVIOR

continued

Individual Educational Plan

Julian Preschool

Student's Name Alberto .

Instructional Area(s) Own Care

Annual Goal(s) dress/undress without assistance when using the toilet

OBJECTIVES	INSTRUCTIONAL METHODS	EVALUATION PLAN and CRITERIA
Alberto will . . .		
a. unzip and zip a zipper on pants.	SHAPING MODELING	USE OF A BEHAVIOR RATING CHECKLIST
b. unbutton and button a button on	VERBAL, MANUAL AND VISUAL PROMPTING	Criteria
c. unbuckle and buckle a buckle on belt.		cannot do it = 0 begins to try = 1 does it with help = 2 does much alone = 3 does it alone = 4
d. unsnap and snap a snap on pants.		
e. put on and remove elasticized pants.		Sample
f. put on and take off pants with snaps (or buttons) and zipper.		unzips 01234 zips 01234 unbuttons01234

continued

Individual Educational Plan

Julian Preschool

Student's Name Alberto

Instructional Area(s) Language Development

Annual Goal(s) To increase verbal experssion skills between peers and teachers.

	OBJECTIVE	STRATEGY	EVALUATION
a.	uses speech to attract attention of peer or caregiver	shaping	frequency of behavior
b.	names several objects	shaping, modeling	frequency of behavior
c.	makes one word requests	shaping, modeling	frequency of behavior
d.	expresses gratitude verbally	shaping, modeling	critical incidence method
e.	describes or designates an object	anecdotal record, modeling	frequency of behavior
f.	names, directs, or describes an action	modeling	frequency of behavior
g.	uses real two-word combinations	chaining behavior, modeling	frequency of behavior
h.	uses varied forms of word combinations (location, possession, nonexistence, negation, questions, action-recipient)	chaining behavior, modeling	frequency of behavior
i.	uses 50 words	modeling	frequency of behavior
j.	combines several parts of speech	chaining behavior, verbal prompting	frequency of behavior
k.	uses compound sentences	chaining behavior, verbal prompting	frequency of behavior
l.	ask 3-4 word questions	modeling, verbal prompting	frequency of behavior
m.	uses sentences of 4-8 words in length	chaining behavior, modeling	frequency of behavior
n.	shares (during conversation or show and tell), information about activities/events experienced	verbal prompting	simple yes-no statement

continued

	OBJECTIVE	STRATEGY	EVALUATION
o.	retells stories of actual events or from books	verbal prompting	simple yes-no statement
p.	requests favorite activities or objects by asking complete questions or making statements of preference	verbal prompting	frequency of behavior simple yes-no statements
q.	uses staetements of over seven words in length	chaining behavior, modeling	frequency of behavior
r.	converses with other adults and children	chaining behavior, modeling	anecdotal record

FUNCTIONAL APPROACH CHECKLIST

Functional descriptors used for individual's capabilities
Y N

Functional descriptors used for limitations
Y N

Functional analyses of the child's range of developmental capabilities included
Y N

Functional analyses are adapted to the child's handicap
Y N

Evaluation is formative (constructive, practical, inferential)
Y N

Evaluation is summative (cumulative, additory, chain)
Y N

Assessment of dysfunctions cross functional domains
Y N

APPENDIX K
EVALUATION FORM
FOR RESIDENTS

PROGRAM EVALUATION

****

YEAR OF RESIDENCY _____

AREA OF CONCENTRATION _____

****

Please rate each of the following:	EXCELLENT				POOR
Organization of program content	5	4	3	2	1
Suitability of notebook materials	5	4	3	2	1
Clarity of explanitations	5	4	3	2	1
Encouragement for discussion	5	4	3	2	1
Stimulation of thinking	5	4	3	2	1
Achievement of program objectives	5	4	3	2	1
Relevancy of program to your needs	5	4	3	2	1
overall rating of seminar	5	4	3	2	1

COMMENTS:

APPENDIX L

PRE- AND POST
TEST RESULTS

20 RESIDENTS

10 QUESTIONS

PRE-TEST RESULTS

RANGE OF CORRECT RESPONSES = 0 - 4

$\overline{X}$ = 1.250

SD = 1.118

POSTTEST RESULTS

RANGE OF CORREST RESPONSES = 7 - 10

$\overline{X}$ = 9.450

SD = .887

t score = 7.069

APPENDIX M

RESIDENT EVALUATION RESULTS

RESIDENT EVALUATION RESULTS

	1st Year		2nd Year		3rd Year	
	C	A	C	A	C	A
organization	5	5	5	5	5	5
note books	5	5	5	5	5	5
clarity	5	5	5	5	5	4
discussion	5	5	4	5	5	3
thinking	5	5	5	4	5	4
objectives	5	5	4	4	5	4
relevancy	5	2	5	1	5	2
overall	5	4	5	4	5	4
	C=7		C=4		C=3	
	A=1		A=2		A=3	
	N=8		N=6		N=6	

SCALE = 5 (excellent) to 1 (poor)

C = child psychiartic resident

A = adult psychiatric resident

N = total resident population by year

scores were tablulated by averaging each subcatagory